

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~retained~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02503

CERTIFICATE OF DEATH

02498

1. DECEASED-NAME (Type or print) Mamie Myrtle Adams			2a. DATE OF DEATH Month February Day 24 Year 1969		2b. HOUR P 5:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 16 April 1896		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE North Carolina	13b. COUNTY Y	13c. CITY OR TOWN Jonesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Route 1	
14. FATHER'S NAME First Middle Last Gordon Bilson Vestal		15. MOTHER'S MAIDEN NAME First Middle Last Bethania Victoria Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptococcal Meningitis 203X DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months 2 Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that NO (this hospital) attended the deceased from 5 Feb. , 19 69 , to 24 Feb. , 19 69 , that NO (we) last saw the deceased alive on 24 February 1969 , and that in NO (our) opinion death occurred on the date and hour and from the causes stated above NO (we) (did) (did not) view the body after death.					
22b. SIGNATURE David S. Fedson M.D.				22c. DATE SIGNED 25 February 1969	
22d. PHYSICIAN'S NAME (Type) David S. Fedson, MD		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2-28-69	23c. NAME OF CEMETERY OR CREMATORY Swan Creek Baptist		23d. LOCATION (City or Town) (County) (State) Jonesville North Caro	
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

61125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>William H Allen</i>					2a. DATE OF DEATH Month <i>Feb</i> Day <i>19</i> Year <i>1969</i>		2b. HOUR <i>1 P</i> M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6/8/09</i>		6. AGE (In years lost birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp. Bldg.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6002 Coral Sea Ave</i>	
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Henry</i> Last <i>Allen</i>			15. MOTHER'S MAIDEN NAME First <i>Addie</i> Middle <i>Huffman</i> Last <i>Huffman</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i> (If yes give war or dates of service) <i>1928-1935</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Richard Lee Allen</i>		Address <i>6510 Waltham Ave Baltimore, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Basilar Artery Thrombosis</i> <i>4320</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cerebro-vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5-10 yrs</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>28 hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 18</i> , 1969, to <i>Feb 19</i> , 1969, that (I) (we) lost the deceased alive on <i>Feb 18</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James R. Moore</i> MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Feb 19, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>James R. Moore</i>				22e. ADDRESS <i>570 N. Frederick Ave Gaithersburg, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/22/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</i>				25a. REGISTRATION DATE <i>FEB 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

[Handwritten signature]
James H. Moore

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Margaret</i>			First <i>March</i> Middle <i>Ashford</i> Last			2a. DATE OF DEATH Month <i>2</i> Day <i>14</i> Year <i>69</i>		2b. HOUR <i>71</i> M		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>3-23-1900</i>		6. AGE (In years lost birthday) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Rockville Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley N.H.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Music Instructor</i>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>11 Washington Circle</i>	
14. FATHER'S NAME First <i>PHILIP</i> Middle <i>M.</i> Last <i>Ashford</i>			15. MOTHER'S MAIDEN NAME First <i>Edna</i> Middle <i>LYDA</i> Last <i>Nixon</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>519-58-5517</i>		17. INFORMANT <i>Lewis T. Breuninger Jr.</i>		Address <i>13408 Glen Leary Road Rockville Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <i>Pulmonary Edema & Infection</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i>myocardial infarction due to coronary a. sclerosis</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Infant old, left cerebral infarction & cerebral arterio sclerosis</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>10-3</i> , 19 <i>67</i> , to <i>2-19</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2-19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Henry C. Seruggs</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/20/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>HENRY C. SERUGGS</i>			22e. ADDRESS <i>5413 Cedar Lane Bethesda Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE <i>2-21-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CREMATORY</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, PRINCE GEORGES Co. D.</i>				
24. FUNERAL DIRECTOR <i>JOSEPH GAULET</i>			ADDRESS <i>5130 WISC. AVE. N.W., WASH. D.C. 20016</i>		25a. REC'D BY REGISTRAR <i>DATE FEB 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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111270 24 114 111270

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MEDICAL CERTIFICATION

02506				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02501							
1. DECEASED-NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH				2b. HOUR				
CLARA				Mae		Ann	2	Month	2	Day	1969	5	PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
F		White		10-7-1876			92 YRS.		MONTHS		DAYS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
W.Va.		Amer.				Montgomery Md.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park			Washington San E Hospital			Housewife			None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
Md.			Montgomery			Takoma Park			YES <input type="checkbox"/> NO <input type="checkbox"/>			504 Philadelphia Ave			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost				
Jacob			B.		Criser	Alice Crawford									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No						MRS. ALICE JOSEPH			504 PHILADELPHIA AVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Cerebrovasc thrombosis												25 days			
4339 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
A.S.H.D. & Heart Block & CHF															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
			HOUR A.M. Month Day Year												
			P.M. 19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (the hospital) attended the deceased from July, 1968, to 2-2, 1969, that (I) (we) last saw the deceased alive on 1-31-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
D. L. Longstack M.D. DEGREE												2-2-69			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			Feb. 5, 1969			ARLINGTON NAT'L CEM			ARLINGTON ARL Co. VA						
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
254 Carroll (FNU)												FEB 8 1969		John B. Judge	

10320

OFFICE OF DEATH

10320

10320

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02507

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02502

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Margery Helen Baldwin						2- 1- 1969			8:55						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
F	W	12-13-15	53 YRS.	MONTHS	DAYS	HOURS	MIN.	2- 1- 1969			8:55				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Tolp, Virginia			U.S. Citizen						Montgomery			Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park, Md.			Washington San & Hosp.												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER						
Md.			Mont.			YES <input type="checkbox"/> NO <input type="checkbox"/>			6912 Westmoreland Ave.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
William			Leers												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
						Leonard R. Baldwin			6912 Westmoreland Ave. - Takoma Park						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Conflagration Burns, 85%															
DUE TO, OR AS A CONSEQUENCE OF															
(b) of body surface, self-															
DUE TO, OR AS A CONSEQUENCE OF															
(c) inflicted															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 here)							
				7:00 P.M. 1-30 1969				Deceased was apprehended in blanket soaked in paint remover							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION (Street or R.F.D. No. City or Town County State)							
				Home				(above) Tak, Pk. Montgom. Md							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
22b. DATE SIGNED															
Feb. 1, 1969															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
				Feb 4 - 1969				Edgewood Park				Baltimore, Md			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Arthur Walters				254 Carroll St				DATE FEB 6 1969				Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02508

02503

1. DECEASED-NAME (Type or print) First Middle Last Martha Ellen Ball			2a. DATE OF DEATH Month Day Year 2 21 69			2b. HOUR 8 35 P M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 5/21/02		6. AGE (In years lost birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Sen. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H.S.W.		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. CITY OR TOWN Capitol Hill		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5236 MARLBORO PK.	
14. FATHER'S NAME First Middle Last Allen Griffin			15. MOTHER'S MAIDEN NAME First Middle Last Martha Purdy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Wash. Sen. & Hosp. 700 Carroll Ave T.P.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 150 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) esophageal cancer DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/10, 1967, to 2/21, 1969, that (I) (we) last saw the deceased alive on 2/21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. W. Chamberlain				22c. DATE SIGNED 2/21/69		22d. PHYSICIAN'S NAME (Type) L. W. Chamberlain	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-24-69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR W. W. Chambers & Co.				25. REGISTERED SIGNATURE FEE 26 1969			

00200

RECORDS OF THE

00200

00200

Dr Belden Reap notified coroner's office and department of health 2/7/69
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>02509</div> <div>02504</div>									
1. DECEASED-NAME (Type or print) William Armand Ball						2a. DATE OF DEATH 2 Month 7 Day 69 Year		2b. HOUR 10 PM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 10-6-90		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5904 Coral Sea Ave.	
14. FATHER'S NAME First ? Middle ? Last Ball			15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. ----		17. INFORMANT Address Hospital Records, Takoma Park, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS									MONTHS
157.9 DUE TO, OR AS A CONSEQUENCE OF (b) APPARENT PRIMARY CARCINOMA OF PANCREAS									MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 30, 1967 , to Feb 7, 1969 , that (I) (we) last saw the deceased alive on Dec 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George L Ball DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Feb 7, 1969			
22d. PHYSICIAN'S NAME (Type) George L Ball						22e. ADDRESS 10620 Georgia Ave Silver Spring Md 20902			
23a. BURIAL, CREMATION, REMOVAL Removal		23b. DATE Feb. 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Sylvania Hill Mem. Park Rochester Beaver Pa.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR The S.H.Hines Co. 2901-14th St., N.W.		ADDRESS Wash., D.C.		25a. REC'D BY REGISTRAR FEB 11 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

02510										MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02505																			
Item 6 Film 410 3/4/69 kk										CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or print) First Middle Last <i>ella V. Bankert</i>										2a. DATE OF DEATH Month Day Year <i>Feb. 18 69</i>										2b. HOUR MIN <i>7:30</i>																													
3. SEX <i>F</i>										4. RACE <i>White</i>										5. DATE OF BIRTH <i>June 5-1893</i>										6. AGE (In years lost birthday) YRS. MONTHS DAYS <i>75 85</i>																			
7a. BIRTHPLACE (State or foreign country) <i>Puna</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <i>Montgomery</i>																			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>										13b. COUNTY <i>Mont.</i>										13c. CITY OR TOWN <i>Leesington</i>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <i>10231 Carroll Rd. (Rising)</i>									
14. FATHER'S NAME First Middle Last <i>Edmond Housen</i>										15. MOTHER'S MAIDEN NAME First Middle <i>Rutha Budd</i>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No.</i>										16b. SOCIAL SECURITY NO. <i>176-05-0710</i>										17. INFORMANT Address <i>Richard C. Bankert</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> <i>4119</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe generalized arteriosclerosis years</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3d.</i>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Ascens P. parotid gland</i>																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <i>2/13</i> , 19 <i>69</i> , to <i>2/18</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/18</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE <i>Robert G. Brewer M.D.</i>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <i>2/19/69</i>																													
22d. PHYSICIAN'S NAME (Type) <i>Robert G. Brewer</i>										22e. ADDRESS <i>8505 Old Georgetown Rd.</i>										<i>Bethesda Md.</i>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>2/20/69</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>										23d. LOCATION (City or Town) (County) (State) <i>Hammer York Pa</i>																			
24. FUNERAL DIRECTOR <i>Wayne V. Kenworthy</i>										ADDRESS <i>Hammer Pa.</i>										25a. REC'D BY REGISTRAR <i>Feb 24 1969</i>										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																			

MEDICAL CERTIFICATION

85210

43002

(REVERSE OF 85210)

[Faint, illegible handwriting on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
02511			02506								
1. DECEASED NAME (Type or print) Angelo Joseph BARGAGNI			First			Middle			Last		
3. SEX Male			4. RACE White			5. DATE OF BIRTH April - 21 - 1879			2a. DATE OF DEATH Feb 22 1969		
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (In years last birthday) 89 YRS. 10 MONTHS 1 DAYS		
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton Nursing Home			9. COUNTY OF DEATH Montgomery			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Montgomery			13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Bargagni Middle Joseph Last Joseph			15. MOTHER'S MAIDEN NAME First Julia Middle Trantow Last Trantow			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fire Chief			13e. STREET AND NUMBER 9923 LaDuke Drive		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT His Daughter			12b. KIND OF BUSINESS OR INDUSTRY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Parkinsonism 342x DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 19 63 , to 2-22-69 , that (I) was last saw the deceased alive on 2-22-69 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.											
22b. SIGNATURE G.F. Sengstack M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 2-22-69					
22d. PHYSICIAN'S NAME (Type) G.F. Sengstack						22e. ADDRESS					
23a. BURIAL CRYPT OR OTHER PLACE (Specify) XXXX			23b. DATE 2-26-69			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS 7557-WISCONSIN AVE, BETHESDA, Md.						25a. REC'D BY REGISTRAR FEB 26 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

2025

340

9953-1 ADAMS, L. E. KENNEDY

Josephs, D. 3

90-25-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print) Agnes H Beckert		First Middle Last		2a. DATE OF DEATH Month Feb. Day 15 Year 1969		2b. HOUR 4:55 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 8, 1905		6. AGE (In years lost birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montg. County Md.	
10. CITY OR TOWN OF DEATH Silverspring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montg		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12809 Epping Terrace		14. FATHER'S NAME First John Middle - Last Hammett		15. MOTHER'S MAIDEN NAME First Ella Middle - Last Bradley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates at service) -	
16b. SOCIAL SECURITY NO. No		17. INFORMANT George E. Beckert		Address Wheaton, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF THE LUNG 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/7 , 19 69 , to 2/15 , 19 69 , that (I) (we) last saw the deceased alive on 2/15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard H. Pollen MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/16/69	
22d. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN		MD MD		22e. ADDRESS 10400 CONNECTICUT AVE KENSINGTON MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-19-1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Prince Georges Md.	
24. FUNERAL DIRECTOR C. Glen Carter		ADDRESS Sil. Spr., Md.		25a. REC'D BY REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE Williamas Judge	

05215

STATE OF TEXAS

05215

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are faintly visible.]

[Faint text at the bottom of the page, possibly a footer or additional document information.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Peter. (None) Beliaett						Month Day Year			M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White.			Oct 6 1904			64 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Lubin Poland			USA						Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hosp			Technical Researcher					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Montgomery			Kensington			4520 Everett St		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Anthony - Beliaett			Katherine Shukowsky								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
unknown			121-26-7605			Anthony Beliaett			4520 Everett St Kensington Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 1621										Known Oct 68	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
Chronic bronchitis with emphysema.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Feb 26, 1966, to Feb 22, 1969, that (I) (we) last saw the deceased alive on Feb 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Carol H. Trauma MD			Feb 22, 1969								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
			8237 Georgia Ave Silver Spring Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2-25-69			St. Vladimir's Cemetery			Cassville New Jersey		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTERED SIGNATURE		
Robert A Pomphrey			755 WILSONS IN AL			FEB 25 1969			John Judge		
			Bethesda Md			DATE					

02302

UNITED STATES OF AMERICA

02302

FEB 2 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

02514

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02509

1. DECEASED-NAME (Type or print) First Middle Last Mildred A. BELL			2a. DATE OF DEATH Month Day Year February 19 69		2b. HOUR 420PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH May 28, 1933		6. AGE (In years last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS 8 21
7a. BIRTHPLACE (State or foreign country) Rhode Island	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida	13b. COUNTY V	13c. CITY OR TOWN Warrington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 213 Rue Max	
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. None	17. INFORMANT Warrington Address Florida GMC1 Coye L. Bell, USN 213 Rue Max		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 7466 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital heart disease; duplication of mitral valve</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 17, 19 69, to Feb. 19, 19 69, that (X) (we) last saw the deceased alive on Feb. 19, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald D. Gaskins				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 20 Feb. 1969
22d. PHYSICIAN'S NAME (Type) Ronald D. Gaskins, M. D.				22e. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-24-69	23c. NAME OF CEMETERY OR CREMATORY Calverly Cemetery		23d. LOCATION (City or Town) Berkley	(County) (State) Rhode Island
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.			25a. REC'D BY REGISTRAR DATE FEB 25 1969		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

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EXHIBIT OF 0-44

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02515

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02510

1. DECEASED NAME (Type or Print) <i>Margaret</i>		First		Middle		Last <i>Belt</i>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <i>Feb 6</i> 19 <i>69</i> ? M				2b. HOUR <i>10</i> A.M.	
3. SEX <i>F</i>	4. RACE <i>Cau</i>	5. DATE OF BIRTH <i>Mar. 21-1884</i>		6. AGE (in years lost birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month <i>Feb.</i> Day <i>8</i> Year <i>1969</i>			2d. HOUR <i>10</i> A.M.
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.							
10. CITY OR TOWN OF DEATH <i>Cherry Chase</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3713 Cherry Chase Rd.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Federal Service</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3713 Cherry Chase Rd.</i>					
14. FATHER'S NAME First <i>Charles</i> Middle <i>Belt</i> Last <i>Belt</i>		15. MOTHER'S MAIDEN NAME First <i>E. Elizabeth</i> Middle <i>Turner</i> Last <i>Turner</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Richard S. Anderson</i>				ADDRESS <i>Rt. 5 Mt. Vernon Ohio</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction Acute</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Coronary Arterio Sclerosis-Severe</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Feb. 9, 1969</i>			
ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-11-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Grove Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>Lancaster, Ohio</i>					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>FEB 13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard S. Anderson</i>							

08210

08210

RECEIVED - DEPT. OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
45M - 1/69

<div>02516</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02511</div>													
1. DECEASED-NAME (Type or print)			First Robert		Middle Walton		Last BENEFIELD, JR.		2a. DATE OF DEATH February 19 Day 69 Year		2b. HOUR 4:40A M		
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH Dec. 5, 1968			6. AGE (In years lost birthday) YRS. 2 MONTHS 14 DAYS		IF UNDER 1 YEAR HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Alaska			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Pr. George			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Barber's Trailer Court		
14. FATHER'S NAME First Robert			Middle Walton			Last Benefield Sr.			15. MOTHER'S MAIDEN NAME First Janice			Middle Marie Last Crist	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N/A			(If yes give war or dates of service) N/A			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Court, Laurel, Md Robert W. Benefield Sr., Barber's Trailer				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>486x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Osteogenic imperfection</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10</u> , 19 <u>69</u> , to <u>Feb. 19</u> , 19 <u>69</u> , that (we) last saw the deceased alive on <u>Feb. 19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>J. K. Howe M.D.</u>			DEGREE			ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 19, 1969	
22d. PHYSICIAN'S NAME (Type) J. K. HOWE, M.D.			22e. ADDRESS Naval Hospital, Bethesda, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/22/69		23c. NAME OF CEMETERY OR CREMATORY Popular Springs			23d. LOCATION (City or Town) LAKELAND		(County) Lanier Ga.		(State)	
24. FUNERAL DIRECTOR Laurel Funeral Home 550 Washington, Blvd. Laurel, Md.			25a. REC'D BY REGISTRAR HOWARD H. FLEIN			25b. REGISTRAR'S SIGNATURE FEB 24 1969							

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
Frank			Hale			Feb/26/1969		5 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
M	W	Aug 30 1953	13 YRS.			March 1 1969		11:45 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Tenn.		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Woodlawn Green Tree Rd.			Student			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.			Montgomery		Bethesda	YES	6804 Newbold Drive.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT			
Frank			Hale - Bertfield			H. Father			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No			None		Frank B. Bertfield		Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot - Wound of Head - 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR:MM 5 PM 2/26/1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self in head with 22 cal. rifle.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Woodlawn		21f. LOCATION Street or R.F.D. No. City or Town County State H Green Tree Rd. Bethesda - Montgomery Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			JOHN G. BALL			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			JOHN G. BALL			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3/1/69	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-4-69		Gate of Heaven		Silver Spring, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland					MAR 5 1969		Charles Judge		

08213

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Andrew J. Betz</i>						2a. DATE OF DEATH <i>Feb.</i> Month <i>2</i> Year <i>1969</i>			2b. HOUR <i>8:30 PM</i>		
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>1/28/04</i>			6. AGE (In years last birthday) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Dr</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Montg Wheaton</i>			13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2906 Weller Rd Sil Sp Md.</i>	
14. FATHER'S NAME First <i>Andrew J</i> Middle <i>Betz</i> Last				15. MOTHER'S MAIDEN NAME First <i>Franceska</i> Middle <i>De Grass</i> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs Ann Mc Dowell. 2906 Weller Rd Wheaton Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pul failure - 1888X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastases to Brain & Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca. of Bladder</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>6 Mon</i> <i>12 Mon</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Gumma - secondary to above</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/21, 1968</i> to <i>2/5, 1969</i> , that (I) (we) last saw the deceased alive on <i>2/5, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen H. Jones</i>						22c. DATE SIGNED <i>2/5/69</i>		22d. PHYSICIAN'S NAME (Type) <i>Stephen H. Jones</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2/8/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate Of Heaven Cem</i>		23d. LOCATION (City or Town) <i>Montg Co Md.</i>		County		State	
24. FUNERAL DIRECTOR <i>W.K. Huntemann & Son</i>						ADDRESS <i>5732 Georgia Ave</i>		REC'D BY REGISTRAR <i>W.K. Huntemann</i>		25b. REGISTRAR'S SIGNATURE <i>W.K. Huntemann</i>	
						DATE <i>FEB 10 1969</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15

02519

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02514

1. DECEASED NAME (Type or print) THOMAS GEORGE B BISSETT			2a. DATE OF DEATH Feb Month 14 Day 1969		2b. HOUR 6:50 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 4-2-89		6. AGE (In years lost birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 10 DAYS 12 IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) POTOMAC VALLEY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TAX DRIVER	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 10558 MCARTHUR BLVD		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN POTOMAC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10558 MCARTHUR BLVD, FORMER, MD
14. FATHER'S NAME First Middle Last Thomas E BISSETT		15. MOTHER'S MAIDEN NAME First Middle Last NANCY W. KITCHEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) YES		16b. SOCIAL SECURITY NO. 62421 578-14-9301 A	17. INFORMANT Mr. Charles Coker 10558 MCARTHUR BLVD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) <u>generalized atherosclerosis</u> stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-22, 1968, to 2-14, 1969, that (I) (we) last saw the deceased alive on 2-4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald C. Bucy / S. SNOWES DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2-14-69
22d. PHYSICIAN'S NAME (Type) Donald C. Bucy				22e. ADDRESS 809 VEIR'S Mill Rd Rockville	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		23b. DATE 2-17-69		23c. LOCATION (City or Town) (County) (State) Potomac Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557-Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR DATE FEB 17 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>02520</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> </div>												<div> <div>CERTIFICATE OF DEATH</div> <div>02515</div> </div>	
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
ESTHER				B. BLACKER				Feb. Month 19 Day 1969				4:30	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Cacu.		Nov. 18, 1911				57 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Colo.		USA				Montgomery Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Gakoma Park				Wash Hosp & San Rental Clerk								Housing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Montgomery		Silver Spring				1705 East-West Hwy.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Henry Joseph				Unk									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
NO				223-22-7596		Helene Axler 3009 Blueford Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Pulmonary emboli - & lobes pneumonia</u>												1 week	
1621 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												5 months	
(b) <u>malignancy of left lung</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>51</u> , to <u>2/19</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Hebert Wechsler</u>										2/20/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
<u>Hebert Wechsler</u>				<u>1800 Eye St N.W. Wash D.C.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>				Feb. 21, 69		<u>National Memorial Park Falls Church, Va.</u>							
24. FUNERAL DIRECTOR				4217 9th St. NW				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Goldberg Fun'l Home</u>				<u>Washington DC.</u>				DATE <u>FEB 24 1969</u>		<u>Charles Judge</u>			

1935

STATE OF NEW YORK

1935

IN SENATE
JANUARY 15, 1935

Charles E. Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02521

CERTIFICATE OF DEATH

02516

1. DECEASED-NAME (Type or print) FRANCES Edgecombe BLAKE			2a. DATE OF DEATH Month 25 Day 6 Year 1969			2b. HOUR 5:30 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH NOV 13 1880		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MAINE		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHERRY CHASE 159 HARRIS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Genealogist		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2015 East-West Highway	
14. FATHER'S NAME First Middle Last EDWARD Edgecombe		15. MOTHER'S MAIDEN NAME First Middle Last Flora YATES		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No					
16b. SOCIAL SECURITY NO. 578-44-8219A		17. INFORMANT Son Francis E. Blake Monroeville, Penna.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized A-S- PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Years Years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1966 to Feb 25 1969 , that (I) (we) last saw the deceased alive on 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.W. DANISH		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-25-69			
22d. PHYSICIAN'S NAME (Type) A.W. DANISH		22e. ADDRESS 1106 SPRINGS ST. S-S-Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-1-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <i>Winifred H. B. Blake</i>		First Middle <i>BLAKE</i> Last		2a. DATE OF DEATH Month <i>2</i> Day <i>16</i> Year <i>69</i>			2b. HOUR <i>1:30</i> M		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 24-1885</i>		6. AGE (In years lost birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>U.S.A. Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Cherry Chase</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>B/SS/NH 8700 Grosvenor Mill Rd. Bethesda</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>MONTG.</i>		13c. CITY OR TOWN <i>BETHESDA</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5618 Moss Ave</i>	
14. FATHER'S NAME First <i>JOHN</i> Middle <i>-</i> Last <i>DINKE</i>		15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>-</i> Last <i>PROBECK</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578-62-2023</i>		17. INFORMANT Address <i>MARY E. BLAKE - SAME AS #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>Generalized metastatic disease</i> <i>1533</i> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Adenocarcinoma sigmoid colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 years</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <i>Nov 10 63</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer sigmoid</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 3</i> , 19 <i>63</i> , to <i>Feb 16</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>Feb 16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>C. P. Ryland</i>		DEGREE <i>C.P. RYLAND</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-16-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>C.P. RYLAND</i>		22e. ADDRESS <i>4400 - 49th St. N.W., WASH., D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE <i>2/17/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CREM.</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, P.G. MD.</i>			
24. FUNERAL DIRECTOR <i>JOSEPH H. SAINLERS</i>		25a. RECEIVED BY REGISTRAR <i>5130</i>		25b. REGISTRAR'S SIGNATURE <i>W. J. SAINLERS</i>		25c. DATE <i>FEB 18 1969</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
02523					02518					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First <i>Leah</i> Middle <i>Hobbs</i> Last <i>Block</i>					Month <i>February</i> Day <i>9</i> Year <i>1969</i>			<i>12:05</i> PM		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Apr. 24, 1887</i>			6. AGE (in years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Wash. DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8716 Cameron Street</i>			12a. USUAL OCCUPATION (Kind of work done during last of work in life, even if retired.) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8716 Cameron Street</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>--</i> Last <i>Hobbs</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>--</i> Last <i>Siltman</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service) <i>--</i>			16b. SOCIAL SECURITY NO. <i>579-28-1268</i>		17. INFORMANT <i>Charles A. Block</i> Address <i>3508 Harrell Street Wheaton, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASHD</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> <i>5 yrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>7-15, 1965</i> , to <i>2-9, 1969</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>2-1, 1969</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> (did) (did not) view the body after death.										
22b. SIGNATURE <i>R. J. Sengstack M.D.</i> DEGREE <i>MD.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-9-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>George F. Sengstack</i>					22e. ADDRESS <i>9241 Columbia Blvd. Sil. Spr., Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE <i>2-12-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Pr. Georges., Md.</i>				
24. FUNERAL DIRECTOR <i>C. Glen Carter</i> ADDRESS <i>Sil. Spr., Md.</i>					25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
					DATE <i>FEB 17 1969</i>					

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0551

Color	Label	Value	Color	Label	Value
White	100	100	White	100	100
Black	100	100	Black	100	100
Blue	100	100	Blue	100	100
Green	100	100	Green	100	100
Yellow	100	100	Yellow	100	100
Orange	100	100	Orange	100	100
Pink	100	100	Pink	100	100
Purple	100	100	Purple	100	100
Brown	100	100	Brown	100	100
Grey	100	100	Grey	100	100
White	100	100	White	100	100
Black	100	100	Black	100	100
Blue	100	100	Blue	100	100
Green	100	100	Green	100	100
Yellow	100	100	Yellow	100	100
Orange	100	100	Orange	100	100
Pink	100	100	Pink	100	100
Purple	100	100	Purple	100	100
Brown	100	100	Brown	100	100
Grey	100	100	Grey	100	100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02524					02519				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First		Middle		Last		Month		Day	
SELMH		C.		BLOMGREN		2		18	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		6-29-75		93 YRS.		MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
SWEDEN		U.S.				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		ALTHEA WOODLAND		Housewife		own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
STATE		--		Washington				4823 16th Street, N. W.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First		Middle		Last		First		Middle	
Sven		A.		Nelson		(Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		578-62-8066		Thelma B. Delore		4823 16th Street, N.W., Wash., D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia, Hypostatic</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC VASCULAR DISEASE.</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SENILITY</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>Feb</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Bernard A. Fitzgerald</u>		M.D.		<input checked="" type="checkbox"/>				2-18-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
BERNARD A. FITZGERALD		217 UNIV. BLVD. E, SILVER SPRING, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		2-20-1969		Oakland Cemetery		Warren, Pennsylvania			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C. Glen Carter		Sil. Spr., Md.		FEB 21 1969		<u>Charles Judge</u>			
Warner E. Pumphrey, Inc. 8434 Georgia Avenue									

02521

02521

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

NAME: _____

DATE: _____

LOCATION: _____

CAUSE OF DEATH: _____

SIGNATURE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 02525 02520 </div> <div style="display: flex; justify-content: space-between;"> Item 6 Film 409 2/25/69 kk CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) First Middle Last Mary Magdaline Blosser						2a. DATE OF DEATH Month Day Year February 19, 1969			2b. HOUR 6 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH September 7, 1908			6. AGE (In years last birthday) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Virginia			13b. COUNTY Page		13c. CITY OR TOWN Stanley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 1		
14. FATHER'S NAME First Middle Last Ambrose Reinheart				15. MOTHER'S MAIDEN NAME First Middle Last Nancy Shomore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Patient's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) uremia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 months 1-2 wks.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid arthritis											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year —		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 , to Feb 19 , 19 69 , that (I) (we) lost saw the deceased alive on Feb 18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. H. Sandstrom				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/19/69					
22d. PHYSICIAN'S NAME (Type) R.H. Sandstrom MD				22e. ADDRESS 7701 Carroll Ave Takoma, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 22, '69		23c. NAME OF CEMETERY OR CREMATORY S.D.A. Church Cemetery			23d. LOCATION (City or Town) (County) (State) Stanley Pa.				
24. FUNERAL DIRECTOR —		ADDRESS 254 Carroll St NW			25a. REC'D BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE —				
					DATE FEB 21 1969						

03250

CENTRAL OF ALABAMA

03250



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 02526 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02521 </div>																							
1. DECEASED-NAME (Type or print)				First Marjorie				Middle J.				Last BODEN				2a. DATE OF DEATH February Month 17 Day Year 69				2b. HOUR 1231 P.M.			
3. SEX Female				4. RACE Caucasian				5. DATE OF BIRTH Jul. 18, 1925				6. AGE (In years last birthday) 43 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) England				7b. CITIZEN OF WHAT COUNTRY? England				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.											
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 7501 Democracy Blvd.							
14. FATHER'S NAME First Middle Last Cook				15. MOTHER'S MAIDEN NAME First Middle Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. None				17. INFORMANT Democracy Blvd. Bethesda, Md. Group Capt. James E. Boden, RAF, 7501											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage due to ruptured aneurysm</u> <u>4309</u> DUE TO, OR AS A CONSEQUENCE OF <u>middle cerebral artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State February 17 February															
22a. I certify that (1) (this hospital) attended the deceased from 6:00 A.M. 17, 19 69, to 12:31 P.M. 17, 19 69, that (2) (we) last saw the deceased alive on 17 February 19 69, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) (did) (not) view the body after death.																							
22b. SIGNATURE <i>C. B. Early</i>				22c. DATE SIGNED 2-18-69				22d. PHYSICIAN'S NAME (Type) C. B. EARLY, M.D. Ph. D.				22e. ADDRESS Naval Hospital, Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE 2/19/69				23c. NAME OF CEMETERY OR CREMATORY J. William Lee's Sons Co.				23d. LOCATION (City or Town) (County) (State) Washington, D.C.											
24. FUNERAL DIRECTOR J. William Lee's Co.				ADDRESS 4th and Massachusetts Ave., N.E. Washington				25a. REC'D BY REGISTRAR FEB 24 1969				25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>											

1835

RECEIVED

1835

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 410 Maryland STATE DEPARTMENT OF HEALTH
3-24-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02522

1. DECEASED NAME (Type or Print) RAYMOND			First Middle Lost			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 2-7-1969			2b. HOUR 7A				
3. SEX MALE		4. RACE W		5. DATE OF BIRTH 3/18/22		6. AGE (In years lost birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) W. VA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY MONT		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 602 CRABB AVE			
14. FATHER'S NAME Lacey			First Middle Lost			15. MOTHER'S MAIDEN NAME Bolen			First Middle Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 234-28-7572			17. INFORMANT David L. Blankenship			ADDRESS Same as item 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a) Multiple internal injuries incurred in vehicular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 3:00 P.M. 2-3 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Deceased was passenger in truck which collided with another truck.					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street -- 7500 block				21f. LOCATION Street or R.F.D. No. City or Town County State Muncaster Mill Rd. Rockville Montg. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Feb. 7, 1969					
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial-transit		2/9/1969						Raleigh, W. Va.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR FEB 13 1969		25b. REGISTRAR'S SIGNATURE Charles Jones			

2250

1931 Rockville Pike
Tyson Wheeler Funeral Home, Inc. Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M TV

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02528

CERTIFICATE OF DEATH

02523

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 S. VanBuren St.		d. STREET ADDRESS 117 S. VanBuren St.	
3. NAME OF DECEASED (Type or print) First Albert Middle M. Last Bouc		4. DATE OF DEATH Month Feb. Day 24 Year 19 69	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1882
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY law	
11. BIRTHPLACE (County & State, or foreign country) Rockville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. V. Bouc, Jr.		14. MOTHER'S MAIDEN NAME Alice Almony	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-20-1086	
17. INFORMANT Wm. V. Bouc		Address Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-24 , 19 69 , to 2-24 , 19 69 , that (I) (we) last saw the deceased alive on 2-24 , 19 69 , and that death occurred at 17:30 AM , from causes and on the date stated above.			
22a. SIGNATURE S. N. Jones / R. Bouc		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d. ADDRESS 809 VEIRS MTL Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-27-69	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPERY, ROCKVILLE, MD.		25a. REC'D BY REGISTRAR DATE FEB 28 1969	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

2250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Paul			First Paul Middle rum Last Bouis			2a. DATE OF DEATH Feb. Month 18 Day 69 ear		2b. HOUR 2:15am	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-7-95		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard		12b. KIND OF BUSINESS OR INDUSTRY Industrial Plant			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1911 Marymont Rd.	
14. FATHER'S NAME First Robert Middle - Last Bouis			15. MOTHER'S MAIDEN NAME First Edith Middle M. Last Edward						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) yes (If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 218-20-0294		17. INFORMANT Mrs. Nora E. Bouis Address 1911 Marymont Rd. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Smoked Uter. Prostate with Uremia.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/18/69 , to 2/18/69 , that (I) (we) last saw the deceased alive on 2/18/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Charles Ligon		22c. DATE SIGNED 2/18/69		22d. PHYSICIAN'S NAME (Type) Dr. Charles Ligon		22e. ADDRESS Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE February 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR FEB 21 1969		25b. REGISTRAR'S SIGNATURE Charles J. Judge					

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02530

02525

1. DECEASED-NAME (Type or print) EDITH M. BOWEN			2a. DATE OF DEATH Month 2 Day 11 Year 69			2b. HOUR 6:20 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 25, 1875		6. AGE (In years last birthday) 93 YRS.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall Sanatorium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY Calvert		13c. CITY OR TOWN Pinebrook		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER (Holland Point)		14. FATHER'S NAME First Benj. Middle Stafford Last Bowen		15. MOTHER'S MAIDEN NAME First ? Middle Bowen Last Bowen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 215-54-5017		17. INFORMANT Richard Bowen, Mechanicsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYOCARDITIS DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SENILITY							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1967 , to FEB. 11, 1969 , that (I) (we) last saw the deceased alive on FEB. 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry M. Louden MD DEGREE MD				22c. DATE SIGNED 2-11-69		22d. PHYSICIAN'S NAME (Type) Henry M. Louden md.	
22e. ADDRESS 5206 Narrows Rd. Chevy Chase, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City or Town) (County) (State) Bartow Calvert Md.	
24. FUNERAL DIRECTOR A.G. Sherkness		24a. ADDRESS San Antonio, Port Republic, Md.		25a. RECEIVED BY REGISTRAR FEB 17 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

05230

05230

05230

[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some faint words like "THE", "AND", "OF" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner notified & approved.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02531		CERTIFICATE OF DEATH						02526			
1. DECEASED-NAME (Type or print) <u>JACOB</u> <u>LOUIS</u> <u>BRENNER</u>						2a. DATE OF DEATH <u>Feb</u> <u>26</u> <u>1969</u>				2b. HOUR <u>845</u> AM	
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>5-15-89</u>		6. AGE (In years last birthday) <u>79</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>POLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.					
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1401 BLAIR MILL Rd. Apt 110</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RET. MERCHANT</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Scrap IRON</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>		13b. COUNTY <u>Montg.</u>		13c. CITY OR TOWN <u>SILVER SPRING</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>1401 BLAIR MILL Rd. SS. MD. 1110</u>			
14. FATHER'S NAME First <u>BEREL</u> Middle <u> </u> Last <u>BRENNER</u>				15. MOTHER'S MAIDEN NAME First <u>CHANA</u> Middle <u>PEREL</u> Last <u> </u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16b. SOCIAL SECURITY NO. <u>579-60-0209</u>		17. INFORMANT <u>GRANDSON</u> Address <u>Burton Brenner - 907 Whitehall Ct SS MD</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arter. Hypert. Arter. Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Feb 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb 10</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Isidore Shulman MD</u> DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>2-26-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>ISIDORE SHULMAN</u>						22e. ADDRESS <u>915-19th ST N.W. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE <u>2/27/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELESEVETRYD Cemetery</u>		23d. LOCATION (City or Town) <u>WASH. D.C.</u> (County) <u> </u> (State) <u> </u>					
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY</u> ADDRESS <u>3551-14th St. N.W. WASH. D.C.</u>						25a. REC'D BY REGISTRAR <u>MAR 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
JAMES LLOYD BREWER						FEBRUARY 21 1969			1555 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE		CAUC		21 AUGUST 1964			4 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
FLORIDA		UNITED STATES				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			NAVAL HOSPITAL						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
D.C.					WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		160 CLAGETT ST.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CHARLES LLOYD BREWER			MARGARET ANN BROOKSHER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO					CHARLES L. BREWER 106 CLAGETT ST., WASH., D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>7469</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGENITAL CYANOTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21 FEB 69		CONGENITAL CYANOTIC HEART				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11 FEBRUARY 1969</u> , to <u>21 FEBRUARY 1969</u> , that (I) (we) last saw the deceased alive on <u>21 FEBRUARY 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Russell W. Pratt, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 22 FEBRUARY 1969	
22d. PHYSICIAN'S NAME (Type) RUSSELL W. PRATT, M.D.				22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		22 FEBRUARY 69		ARLINGTON NATL. CEM.		ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR Robert A Pumphrey				24b. ADDRESS 72557 Wisconsin Ave. Bethesda, Md		25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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RECEIVED OF 05221

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>02533</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02528</div>													
1. DECEASED-NAME (Type or print) Vinnie				First Agnes Middle Briggs Last				2a. DATE OF DEATH Feb Month 1st day 69 Year				2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 1st 1888				6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.							
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Rest Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Mont.			13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12 E. Diamond Ave			
14. FATHER'S NAME First George Middle Andrews Last				15. MOTHER'S MAIDEN NAME First Sallie Middle King Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Jesse D. Briggs. Gaithersburg. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) C. V. A.												6 days	
4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Arteriosclerotic Heart Disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Hypertension.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19 to 2-1-1969 , that (I) (we) last saw the deceased alive on 2-31-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE L. I. Leal M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) L. I. Leal M.D.								22e. ADDRESS Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		2-3-69		Forest Oak				Gaithersburg, Mont.					
24. FUNERAL DIRECTOR Ernest C. Gartner. Gaithersburg. Md.								25a. REC'D BY REGISTRAR FEB 5 1969		25b. REGISTRAR'S SIGNATURE			
Ernest C. Gartner													

MEDICAL CERTIFICATION

03330

LETTER TO THE DIRECTOR

03330

TO THE DIRECTOR, BUREAU OF THE ARMY

FROM THE DIRECTOR, BUREAU OF THE ARMY

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 410 Maryland State Department of Health
3-12-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02534

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02529

1. DECEASED-NAME (Type or Print) First Middle Last RICHARD DANIEL BROECKEL			2a. DATE KNOWN OF DEATH Month Day Year 2-23-1969			2b. HOUR 3:55 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7-15-29	6. AGE (In years last birthday) 39 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 2 23 1969		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Attorney		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1509 Paula Drive
14. FATHER'S NAME First Middle Last Daniel Broeckel			15. MOTHER'S MAIDEN NAME First Middle Last Marie Selke					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Yes N/A		17. INFORMANT Hospital Chart			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) Belden R. Reap, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Febr. 23, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/26/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		23d. LOCATION (City or Town) (County) (State) New Market, Virginia		
24. FUNERAL DIRECTOR Dellinger Funeral Homes, Inc. Woodstock, Va.				25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE W. C. ...		

6250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02535

CERTIFICATE OF DEATH

02530

1. DECEASED-NAME (Type or print) <i>Edythe</i>		First <i>M.</i>	Middle	Lost	2a. DATE OF DEATH Month <i>February</i> Day <i>3</i> Year <i>1969</i>		2b. HOUR <i>11:40 A.M.</i>
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>4/26/1882</i>		6. AGE (In years lost birthday) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS <i>-</i> DAYS <i>-</i> HOURS <i>-</i> MIN <i>-</i>
7a. BIRTHPLACE (State or foreign country) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CONCERT HARPIST</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i> COUNTY <i>-</i>		13c. CITY OR TOWN <i>WASHINGTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4450 Reservoir Rd. N.W.</i>	
14. FATHER'S NAME First <i>William U.</i> Middle <i>Marmion</i> Lost		15. MOTHER'S MAIDEN NAME First <i>Caroline</i> Middle <i>Walker</i> Lost <i>McClellan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>579-14-6148D</i>		17. INFORMANT Address <i>Daughter Mrs. E. Scruggs, SAME ADD.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebrovascular thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 DAYS.</i> <i>3 WKS.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/25/68</i> , 19____, to <i>2/3/69</i> , 19____, that (I) (we) last saw the deceased alive on <i>2/2/69</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Henry C. Scruggs MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR PHYS.		22c. DATE SIGNED <i>2/3/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>HENRY C. SCRUGGS MD</i>		22e. ADDRESS <i>5413 Cedar Lane Bethesda Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-6-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Jos. Gaudier's Sons, Inc, Wise Ave & Harrison St N.W., D.C.</i>		25a. REC'D BY REGISTRAR <i>6</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		FEE <i>6</i> 1969	

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CERTIFICATE OF DEATH

02536

1. DECEASED NAME (Type or print) Budd		First None	Middle —	Last Budd	2a. DATE OF DEATH Month Feb. Day 1 Year 1969		2b. HOUR 7:45 M
3. SEX male		4. RACE Wh		5. DATE OF BIRTH 2-1-69		6. AGE (In years lost birthday) — YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Joseph		Middle Adrian		Last Budd		15. MOTHER'S MAIDEN NAME First Beverly	
Middle Jean		Last Pester		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Father		Address as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 777 X DUE TO, OR AS A CONSEQUENCE OF (b) death. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Immature birth (1 lb 4½ ozs), neonatal		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-1 , 19 69 , to 2-1 , 19 69 , that (I) (we) lost the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Carolyn S. Pincock		DEGREE —		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-5-69	
22d. PHYSICIAN'S NAME (Type) CAROLYN S. PINCOCK		22e. ADDRESS 1944-Seminary Rd. S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/6/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock. Pike		25a. REC'D BY REGISTRAR FEB 7 1969		25b. REGISTRAR'S SIGNATURE [Signature]	
City or Town Rockville, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02330

Immunization (1 in 4 case), neonatal.

Date of heaven

Silver Spring, Maryland

Tyson School (Merry) Nov 1951 - 1952

Washington, D.C.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First		Middle		Last		
FRANK			JOSEPH		BUGGLIN				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2b. HOUR
Male	White	11-3-06		62 YRS.					2b. HOUR 5:40 P.M.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Pennsylvania			U.S.A.				Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park,			Washington San. & Hosp.			Toolcrib Supervisor Litton Inc			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince Geo.		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		7204 24th Avenue
14. FATHER'S NAME			First		Middle		Last		
Aloysius			Bugglin		Crescentia				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS				
No			192-22-3350		Hosp. Record				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 19, 1969		Holy Sepulcher Cemetery		Montgomery County, Penna		
24. FUNERAL DIRECTOR			ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Thomas Funerals Hony J. J. Walter			254 Carroll St. Wash D.C.		FEB 18 1969				

02538

CERTIFICATE OF DEATH

02533

1. DECEASED-NAME (Type or print) First Middle Last Edward Leroy Burch			2a. DATE OF DEATH Month Day Year February 8 1969			2b. HOUR 12:20			
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 1, 1918		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lab technician		12b. KIND OF BUSINESS OR INDUSTRY Chemical			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Kentucky			13b. COUNTY Louisville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1710 Kurz Way		
14. FATHER'S NAME First Middle Last Robert Burch			15. MOTHER'S MAIDEN NAME First Middle Last Mary Cashman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. 1941-1945 400-28-4187		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - Arrest 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Left Ventricular Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Artery Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 - 48 Hrs. 3 Years 10 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 2/5/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 27 January, 1969 , to 8 Feb., 1969 , that (I) (we) last saw the deceased alive on 8 February 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Bradley M. Rodgers MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 8 February 1969			
22d. PHYSICIAN'S NAME (Type) Bradley M. Rodgers, M. D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Feb. 11, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY; LOUISVILLE-Jefferson-Ky.		23d. LOCATION (City or Town) (County) (State) LOUISVILLE-Jefferson-Ky.			
24. FUNERAL DIRECTOR Owen Suburban F. Home ADDRESS 5317 Dixie Highway Louisville, Ky.						25a. REC'D BY REGISTRAR DATE Feb 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event within 72 hours after death.

02539

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02534

Item 13 Film 409 2/17/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Em Aurine D. Burgess</i>			2a. DATE OF DEATH 2 Month 7 Day Year 69			2b. HOUR 1 PM M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 21, 1893</i>		6. AGE (In years lost birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Cherry Chase, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Richesda Sil. Sp. Nurs. Hm.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Frank Donaldson</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Ida Belle Latourette</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>217-44-6918</i>		17. INFORMANT <i>Mrs. Lucile Rowe</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CA of Bladder; Massive Pulmonary Embolism</i> <i>188X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombosis Pelvic Veins</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma Of Bladder</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Multiple Metastasis In Lung, Liver & Skin</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , to <i>present</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb 1</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Long Sharpe MD</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-7-69</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>2-9-1969</i>		23c. NAME OF CEMETERY, DR. CREMATORY <i>Cremation At Lee's</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR <i>LEE Funeral Home</i>		ADDRESS <i>300. 4th. ST N.E.</i>		25a. REC'D BY REGISTRAR <i>FFB II 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1998

Henry Chase, M.D. Director of the New York State

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02540										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02535									
Item 6 Film 410 3/4/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) <i>Ethel</i> First <i>B</i> Middle <i>Cannon</i> Last										2a. DATE OF DEATH Month <i>Feb</i> Day <i>21</i> Year <i>1969</i>										2b. HOUR <i>7:30</i> M									
3. SEX <i>Female</i>					4. RACE <i>White</i>					5. DATE OF BIRTH <i>2/18/90</i>					6. AGE (In years last birthday) <i>79</i> YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (country) <i>MARYLAND</i>					7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>Montgomery</i> Md.														
10. CITY OR TOWN OF DEATH <i>Bethesda</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shubert Hosp</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RESTAURANT PROPRIETOR					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>					13b. CITY OR TOWN <i>Washington</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <i>7700 16 St. N.W.</i>														
14. FATHER'S NAME First <i>George</i> Middle <i>S</i> Last <i>Thomson</i>					15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Browning</i> Last																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>NO</i> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <i>578-18-8093A</i>					17. INFORMANT <i>Son.</i> Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute bronchopneumonia</i> <i>4369</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebro-vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Genl. arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>12 days</i> <i>10 years</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/1</i> , 1968, to <i>2/21</i> , 1969, that (I) (we) last saw the deceased alive on <i>2/21</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>John E. Everett M.D.</i> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. 22c. DATE SIGNED <i>2/21/69</i>																			
22d. PHYSICIAN'S NAME (Type) <i>JOHN E. EVERETT</i>					22e. ADDRESS <i>9400 - CONN. AV. Kensington</i>																								
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>					23b. DATE <i>2-24-69</i>					23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>					23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MARYLAND.</i>														
24. FUNERAL DIRECTOR <i>Francis Realline 500 University Blvd West</i>										25a. REC'D BY REGISTRAR DATE <i>FEB 24 1969</i>										25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>									

4-222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
02541						02536						
1. DECEASED-NAME (Type or print) First Middle Last MARTHA JEAN CARNELL						2a. DATE OF DEATH Month Day Year FEBRUARY 9 1969			2b. HOUR 5:55 AM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 2 OCTOBER 1936			6. AGE (In years last birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH BETHESDA, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VIRGINIA				13b. COUNTY RICHMOND		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1603 CHARLES STREET				
14. FATHER'S NAME First Middle Last RICHARD DAVIS CULLOM				15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH FRANCIS ARRINGTON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO. 227 46 2796		17. INFORMANT Address DENNIS M. CARNELL, 1603 CHARLES ST, RICHMOND, VA.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread Metastatic Carcinoma of Breast 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 29 Jan 1969 , to 9 Feb 1969 , that (I) (we) last saw the deceased alive on 9 Feb 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.												
22b. SIGNATURE <i>D. L. Horton</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9 February 69				
22d. PHYSICIAN'S NAME (Type) D. L. HORTON LT MC USN						22e. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE 2/10/69		23c. NAME OF CEMETERY OR CREMATORY Glendale		23d. LOCATION (City or Town) (County) (State) Richmond, Va.						
24. FUNERAL DIRECTOR J. W. Bliley Funeral Home, Richmond, Va.						25a. REC'D BY REGISTRAR DATE FEB 14 1969		25b. REGISTRAR'S SIGNATURE <i>Glenn L. Venable</i>				

3259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, read completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>George M Carpenter</i>			2a. DATE OF DEATH Month <i>FEBRUARY</i> Day <i>18</i> Year <i>1969</i>			2b. HOUR <i>7:15A</i> M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6/28/06</i>		6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Mass</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Proprietor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Book Shop</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6307 Huntow La</i>	
14. FATHER'S NAME First <i>George</i> Middle <i>S</i> Last <i>Carpenter</i>			15. MOTHER'S MAIDEN NAME First <i>Jeanne</i> Middle <i>Genoull</i> Last <i>Genoull</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>yes</i>		16b. SOCIAL SECURITY NO. <i>WW 11 212-05-4228</i>		17. INFORMANT <i>Wife Martha Carpenter</i>		Address <i>same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> ANT. SERIAL <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CORONARY OCCLUSION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CORONARY ARTERIOSCLEROSIS</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 DAYS</i> <i>14 DAYS</i> <i>2 YEARS</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>BENIGN PROSTATIC HYPERTROPHY, BILAT. HYDRONEPHROSIS</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2 FEB</i> , 1969, to <i>18 FEB</i> , 1969, that (I) (we) last saw the deceased alive on <i>17 FEB</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert G. Angle M.D.</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>18 FEB. 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>ROBERT G. ANGLE, M.D.</i>				22e. ADDRESS <i>5009 DelRay Ave. Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>2-18-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Pr. Geo. Md.</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				7557 Wisconsin Ave. ADDRESS		REC'D BY REGISTRAR <i>FEB 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	

02337

02337

EXHIBIT OF DATA

1. The first part of the data is a list of the names of the persons who were interviewed. The names are listed in alphabetical order. The names are: [illegible]

2. The second part of the data is a list of the names of the persons who were interviewed. The names are listed in alphabetical order. The names are: [illegible]

3. The third part of the data is a list of the names of the persons who were interviewed. The names are listed in alphabetical order. The names are: [illegible]

4. The fourth part of the data is a list of the names of the persons who were interviewed. The names are listed in alphabetical order. The names are: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02543

02538

1. DECEASED-NAME (Type or print) <i>AGNES M. CASTELL</i>			2a. DATE OF DEATH Month <i>FEB</i> Day <i>13</i> Year <i>1969</i>			2b. HOUR <i>8:40</i> M	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>6/14/1888</i>		6. AGE (In years lost birthday) <i>80</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md.	
10. CITY OR TOWN OF DEATH <i>ROCKVILLE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>ROCKVILLE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>15015 ROSECREST RD</i>		14. FATHER'S NAME First Middle Last <i>FRICK</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>068106 884D</i>		17. INFORMANT <i>Mrs. Dennis Sheehan</i>		Address <i>Same as 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cryptone Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intermittent Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i> , to <i>1969</i> , that (I) (we) last saw the deceased alive on <i>13 Feb 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>SEAF S. DAVIN</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>13 Feb 69</i>	
22d. PHYSICIAN'S NAME (Type) <i>SEAF S. DAVIN</i>		22e. ADDRESS <i>4977 Belling Lane Bethesda Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>2-17-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HOLY CROSS CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>BROOKLYN N.Y.</i>	
24. FUNERAL DIRECTOR <i>Norris Hollis</i>				ADDRESS <i>500 University Blvd NW Silver Spring, Md</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 17 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>Blanchard Jones</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02544										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02539																			
1. DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR																			
(Type or print)										Month Day Year										215A M																			
First Middle Last Edmund A. CAWLEY										February 13 1969																													
3. SEX Male					4. RACE Caucasian					5. DATE OF BIRTH May 14, 1924					6. AGE (In years last birthday) 44 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Ohio					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.																								
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) USMC					12b. KIND OF BUSINESS OR INDUSTRY																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER Apt. 913, 3 Pooks Hill																			
14. FATHER'S NAME First Middle Last Anthony J. CAWLEY										15. MOTHER'S MAIDEN NAME First Middle Last ANASTASIA RYAN																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or period of service) Yes 1947-68					16b. SOCIAL SECURITY NO. 447-28-2227					17. INFORMANT Hill, Bethesda, Md Address Mrs. Marguerite Cawley, Apt. 913, 3 Pooks Hill																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Rupture of left carotid artery DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous Cell Carcinoma metastatic to neck DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (A) (this hospital) attended the deceased from June 19, 1968, to Feb. 13, 1969, that (A) (we) lost the deceased alive on Feb. 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE R. P. Majors Jr.										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED Feb. 13, 1969																			
22d. PHYSICIAN'S NAME (Type) R. P. MAJORS, M.D.										22e. ADDRESS Naval Hospital, Bethesda, Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 2-17-69										23c. NAME OF CEMETERY OR CREMATORY SANTA ANA CALIF										23d. LOCATION (City or Town) (County) (State)									
24. FUNERAL DIRECTOR W. W. CHAMBERS CO.										ADDRESS 1400 Chapin Street, N. W. Washington, D. C.										25a. REC'D BY REGISTRAR DATE FEB 20 1969										25b. REGISTRAR'S SIGNATURE Charles Jones									

2525

2525

FEB 20 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02545

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02540

1. DECEASED-NAME (Type or print) Thayapurath (None) Chandran			2a. DATE OF DEATH Month February Day 24 Year 1969			2b. HOUR AM 4:17 M				
3. SEX Male		4. RACE Indian		5. DATE OF BIRTH 16 February 1937		6. AGE (In years last birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		
7a. BIRTHPLACE (State or foreign country) India		7b. CITIZEN OF WHAT COUNTRY? India		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE India			13b. COUNTY Kerala State		13c. CITY OR TOWN Cannanore-8		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. Alavil	
14. FATHER'S NAME First Thayapurath Middle Last Chandran			15. MOTHER'S MAIDEN NAME First Kuthichi Middle Last Narayani							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Low Cardiac output syndrome 3940 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral valve replacement DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Heart Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 13 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION 2/19/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral stenosis			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (X) (this hospital) attended the deceased from 25 January, 1969 , to 24 Feb., 1969 , that (X) (we) last saw the deceased alive on 24 February 1969 , and that in MDX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lynn M. Peterson MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 25 February 1969					
22d. PHYSICIAN'S NAME (Type) Lynn M. Peterson, M. D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL (CREMATION, REMOVAL) (Specify) 		23b. DATE 2-27-69		23c. NAME OF CEMETERY OR CREMATORY 7th Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Bladensburg Md			
24. FUNERAL DIRECTOR W.W. Chambers Co ADDRESS 3072 Mt St NW					25a. REC'D BY REGISTRAR DATE MAR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

(cont.)

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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continued on page 68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 145
45M 1 69

| <div style="display: flex; justify-content: space-between;"> 02546 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02541 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | | | | | | | |
|--|--|--|--|--|--|---|---|---|--|
| 1. DECEASED-NAME (Type or print) <i>Albert</i> First <i>L</i> Middle <i>Chase</i> Last | | | | | 2a. DATE OF DEATH
Month <i>Feb</i> Day <i>21</i> Year <i>1969</i> | | | 2b. HOUR <i>5:30</i> M | |
| 3. SEX <i>male</i> | | 4. RACE <i>Negro</i> | | 5. DATE OF BIRTH
<i>12/3/04</i> | | 6. AGE (In years last birthday) <i>64</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>none</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i> | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN <i>Gaithersburg</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>2101</i> | |
| 14. FATHER'S NAME First <i>Joseph</i> Middle <i>Chase</i> Last | | | 15. MOTHER'S MAIDEN NAME First <i>Lora</i> Middle <i>Bailey</i> Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>4109</i> | | 17. INFORMANT <i>John Mary L Chase</i> | | | Address <i>2101 Corn Ave Wash. D.C.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction, recent & old, Left Myocardium, 10 days</i>
DUE TO, OR AS A CONSEQUENCE OF <i>& Interventricular Septum</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerosis, mark with occlusion</i>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Alcoholism, chance.</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 15, 1969</i> to <i>Feb 21, 1969</i> , that (I) (we) lost saw the deceased alive on <i>Feb 21, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Bruce H. Braden MD</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>2/22/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS <i>10820 Georgia Ave.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>2-25-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Brooke Grove Cem.</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Laytonsville Montg, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Robert L. Braden</i> | | | | ADDRESS <i>Ruckwille Md</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |
| | | | | DATE <i>FEB 26 1969</i> | | | | | |

2000

Abstract

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02547

02542

| | | | | | | | | | |
|---|-------------------------|---|--|---|--------------------------------------|---|---|---|----------------------------------|
| 1. DECEASED-NAME
(Type or Print) First Middle Last
ROSALIE J. CLARK | | | 2a. DATE KNOWN OF DEATH
Month Day Year
Feb. 7, 1969 | | | 2b. HOUR
AM PM
8 AM | | | |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH
7-30-1887 | 6. AGE (in years last birthday)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
Feb. 7, 1969 | 2d. HOUR
AM PM
8 AM |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7514 Old Chester Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
7514 Old Chester Rd. | | |
| 14. FATHER'S NAME First Middle Last
William W. McFarland | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anetta Clark | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
213-48-1703 | | 17. INFORMANT
Husband | | ADDRESS
Same as Item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4124 IMMEDIATE CAUSE (a) coronary Insufficiency Acute.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio Vascular Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden.
years. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
Feb. 7, 1969 | | | |
| EXAMINER'S NAME (Type)
JOHN G. BALL | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county)
Bethesda, Md. | | | | | | |
| 23a. BOARD OF HEALTH REMOVAL (Specify)
Anat. Board | | 23b. DATE
2-7-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Univ. Anat. Board, Medical School | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland. | | | | 25a. REC'D BY REGISTRAR
FEB 10 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15
45M - 11

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>Thelma Elizabeth Cobb</i> | | | | | 2a. DATE OF DEATH Month Day Year
<i>Feb 27 1969</i> | | 2b. HOUR
<i>1:15</i> M | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>6-10-1909</i> | | 6. AGE (In years lost birthday)
<i>60</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT Home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>USA</i> | | 13c. CITY OR TOWN
<i>Hyattsville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>2313 Sheridan St.</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Stanley E. Bailey</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Rhoda Mae Phillips</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>214-10-6288</i> | | 17. INFORMANT Address
<i>Melvin L. Cobb -</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Renal Failure</i>
<i>485X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i>
<i>4 days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Cerebrovascular Accident</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
<i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>2/22</i> , 19 <i>69</i> , to <i>2/27</i> , 19 <i>69</i> , that (1) (we) lost saw the deceased alive on <i>2/26</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Allen M. Mond</i> MD | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/27/69</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>ALLEN M MOND</i> | | | | | 22e. ADDRESS
<i>2150 Pennsylvania Ave NW P.C.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY
<i>Burial</i> | | 23b. DATE
<i>3-4-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mardela Memorial</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Mardela Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Robert A. Pumphrey</i> | | | | | 25a. REC'D BY REGISTRAR
<i>MAR 1 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |
| ADDRESS
<i>Bethesda, Md</i> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
MARY LOUISE COLLIER | | | 2a. DATE OF DEATH
Month Day Year
2 - 06 - 69 | | 2b. HOUR
7:50 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
June 7, 1896 | | 6. AGE (In years)
last birthday 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4890 Battery Lane | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Bureau of Engraving. U.S. Govt. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
4890 Battery Lane |
| 14. FATHER'S NAME First Middle Last
Richard Collier | | 15. MOTHER'S MAIDEN NAME First Middle Last
Teresa Walters | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) **** | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
4890 Battery Lane, Miss Carrie M. Collier, Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY Thrombosis
4100 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
None
10 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from August, 1959 to 2/6, 1969 , that (I) (we) last saw the deceased alive on 2/4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death. | | | | | |
| 22b. SIGNATURE
William T. Saccardi MD | | 22c. DATE SIGNED
2/6/69 | | 22d. PHYSICIAN'S NAME (Type)
William T SACCARDI | |
| 22e. ADDRESS
1150 Corn Ave NW WASH DC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-8-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Monocacy Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Beallsville, Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
7557 Wisconsin Ave. FEB 10 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

03542

03542

CENTRAL DEATH

2 - 00 - 00

COLLIER

LOUIS

MARY

72

June 7, 1890

White

Female

Montgomery

U.S.A.

Maryland

4800 Battery Lane

Bethesda

Montgomery Bethesda

Maryland

Collins

Richard

None

no

4800 Battery Lane,
Bethesda, Md.
Miss Carrie E. Collins

Bethesda, Md.

2-8-02

Bureau

7537 Wisconsin Ave.

ROBERT A. FLETCHER, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|--|--|--------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Jennie | | | HARMEL | | | Conn | | | February 25 1969 4:02 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | WHITE | | 9-4-91 | | 77 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| D.C. | | D.S.A. | | | | MONTGOMERY | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TAKOMA PARK | | | WASHINGTON SAN. & HOSP. | | | TEACHER | | | SCHOOL | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| D.C. | | | V | | | WASH. DC. | | YES | | 2238 CATHEDRAL AVE. N.W. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| PAUL NONE HARMEL | | | ROSA NONE EFFENBACK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| | | | 579-46-0699 | | | HOSPITAL RECORDS, TAKOMA PARK, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Inter cerebral general cerebral, pyramidal</u> | | | | | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Congestive heart failure</u> | | | | | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Death of brain</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1969, to Feb. 28, 1969, that (I) (we) last saw the deceased alive on Feb. 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Chas H Wolohon, MD</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 2-26-69 | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Chas H Wolohon MD</u> | | | | | | 22e. ADDRESS <u>831 Univ Bldg S.W. Tru</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| | | | Feb 27, 1969 | | | ADAS ISRAEL Cemetery | | | WASH. D.C. | | |
| 24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY</u> | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| 3501-146 St N.W. WASH. D.C. | | | | | | DATE MAR 3 1969 | | | <u>Charles Judge</u> | | |

05500

05545

STATEMENT OF DEATH

James M. White
p - 11
X
Montgomery
Washington San. & Hosp.
Wash. D.C.
Tolson
From New Haven
Hospital Records, Tacoma Park, D.C.
2225 Cathedral Ave. N.W.
Effendi

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---------|--|------------------|--|--|---------------------------------|--|--|--|------------------|--|--------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| Hazel | | | KLINE | | | Copenhaver | | | Month Day Year 10:55 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| F. | | W | | 10/6/1881 | | | 87 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| PA. | | | U.S.A. | | | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Rockville | | | Potomac Valley Hosp. & Rehab. Ctr. Falls Church, Va. | | | Employment Agency | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| D.C. | | | V | | | WASH. | | | YES | | | 4740 Conn. Ave. N.W. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| ISAAC AUGUSTUS KLINE | | | ANNA ELIZABETH EYER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| | | | 579-60-5738 | | | WILLIAM K. COPENHAVER, (SON) | | | POTOMAC, MD. | | | 8520 WARDE TERR. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hepatic Failure | | | | | | | | | | | | 1 wk | | |
| 1538 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) Metastases to Liver | | | | | | | | | | | | 3 mos | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) Ca. of colon | | | | | | | | | | | | 1 yr. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/2/66, to 2/9/67, that (I) (we) last saw the deceased alive on 2/9/67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | |
| Stephen N. Jones, M.D. | | | 2/9/67 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | |
| Dr. Stephen N. Jones | | | Rockville, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | Md. | | |
| Burial | | | 2-12-1969 | | | Fort Lincoln Cemetery | | | Colmar Manor, Prince Georges | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016 | | | DATE FEB 13 1969 | | | William Jones | | | | | | | | |

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02552

02547

| | | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or print) LAWRENCE D. COX | | | 2a. DATE OF DEATH
Month 2 - Day 4 - Year 69 | | | 2b. HOUR
1:55 AM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
12-16-12 | | 6. AGE (In years last birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
W. VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cross Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md. | | | 13b. CITY OR TOWN
Bladensburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5308 Newton St #304 | | | |
| 14. FATHER'S NAME First Middle Last
Thomas Cox | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary O'Connor | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) 1935-1946 | | | 16b. SOCIAL SECURITY NO.
560641298 | | 17. INFORMANT Address
Edna A. Cox Bladensburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Disseminated Carcinoma
1890
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypernephroma, Lt. Kidney
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Seven mos.
2 1/2 yrs. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug , 1968, to Feb 4 , 1969, that (I) (we) last saw the deceased alive on 2/3 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
G. Leonard Gold | | | | | 22c. DATE SIGNED
2/4/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
G. Leonard Gold | | | | | 22e. ADDRESS
9801 Georgia ave Silver Springs, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb 7, 1969 | | 23c. NAME OF CEMETERY OR CREMATORIUM
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
F. Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 7 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

7425

52539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 1 Film 410 3/14/69
Item 16b

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02548

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Mary Edith Ann Neal Crutcher | | | 2a. DATE OF DEATH
Month Day Year
2 19 69 | | 2b. HOUR
12:43 AM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
7-14-85 | | 6. AGE (In years last birthday)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Kansas | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery County Md. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Grosvenor Lane Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | 13b. COUNTY
Washington | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
4000 Massachusetts Ave., NW | | |
| 14. FATHER'S NAME First Middle Last
Fernando P. Neal | 15. MOTHER'S MAIDEN NAME First Middle Last
Ida David Adkins | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <input checked="" type="checkbox"/> No | 16b. SOCIAL SECURITY NO.
060-09-2508D | 17. INFORMANT Address
Miss Dorothy Crutcher | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
485X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 hrs |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (1) this hospital attended the deceased from <u>Oct</u> , 1968, to <u>Feb</u> , 1969, that (I) (we) last saw the deceased alive on <u>18 Feb</u> 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>John J. Daum M.D.</u> | | | | 22c. DATE SIGNED
19 Feb 69 | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN J. DAUM | | | | 22e. ADDRESS
4977 Bathy Lane Bethesda | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
2-21-69 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Wash. Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Independence, Mo. | |
| 24. FUNERAL DIRECTOR
Evelyn Wheatley | | ADDRESS
Alexandria, Va. | | 25a. REC'D BY REGISTRAR
DATE FEB 24 1969 | 25b. REGISTRAR'S SIGNATURE
Alexander Under |

000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>astrea</i> | | | First <i>E.</i> Middle <i>Cruz</i> Last | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>19</i> Year <i>69</i> | | | 2b. HOUR
<i>12</i> ^{PM} | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>8/26/23</i> | | | 6. AGE (In years
last birthday)
<i>45</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign
country)
<i>Puerto Rico</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Wash. San. & Hosp</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Typist</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>IBM</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Maryland</i> COUNTY <i>Prince Georges</i> | | | 13c. CITY OR TOWN
<i>Hopkinsville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1523 Madison St.</i> | | | APT <i>302</i> | |
| 14. FATHER'S NAME
First <i>moises</i> Middle <i>Echevarris</i> Last <i>Porfiria</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Collazo</i> Middle <i></i> Last <i></i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown) | | 16b. SOCIAL SECURITY NO.
<i>578-38-9544</i> | | 17. INFORMANT
<i>Hospital chart</i> Address <i></i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>
<i>4462</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <i>Collagen Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i>
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>28 hrs</i>
<i>9 mo.</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>
P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>69</i> , to <i>19 Feb</i> , 19 <i>69</i> , that (I) (we) last
saw the deceased alive on <i>19 Feb</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. J. Lublin</i> | | | | 22c. DATE SIGNED
<i>2/19/69</i> | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | 22e. ADDRESS
<i>WASH. JAN. 3 HOSPITAL, TAKOMA PARK, MD.</i> | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<i>23 FEB. 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>UNKNOWN</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>SAN JUAN PUERTO RICO</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>RINALDI FUNERAL HOME, INC.</i> | | | | ADDRESS
<i>740 GEORGIA AVE. N.W.,
WASHINGTON DC. 20012</i> | | 25a. REC'D BY REGISTRAR
<i>Feb 24 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

03243

RECEIVED 10-10-1964

03243

03243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|--|--|---|---|--|--------------|-----------------------------------|--|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Henry J. Curtis | | | | | | Month Day Year
Feb 9 69 | | | 2:30 A | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | Can | | Aug. 28, 1896 | | | 72 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | | | | Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | | 616 Elm Ave. Jk. Pk. Md. | | | Government Services | | | Admin. Gov't | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | Montgomery | | Takoma Pk. | | | | 616 Elm Street | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| John -- Curtis | | | Carrie -- Moxley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| No | | | Yes 77-05-8979 | | Address Wash., D. C.
Helen Rutledge 4716 Eastern Ave., N.E. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | Acute | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF Upper respiratory infection 2 days | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| Post-op CA of the mouth - to hemorrhage, | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1, 1963, to 2/9, 1969, that (I) (we) last saw the deceased alive on 2/8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | | | | |
| John D. Griswold, M.D. | | 2/10/69 | | 4330 V St., N. W. Washington, D. C. 20007 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Burial | | 2-12-1969 | | Darnstown Presbyterian Cer. | | Darnstown | | Montgomery | | Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| C. Glen Carter | | FEB 17 1969 | | Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02556

CERTIFICATE OF DEATH

02551

| | | | | | | | | |
|---|--|--|--|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) Armand Armand Cyr | | | 2a. DATE OF DEATH
Feb Month 23 Day 1969 | | | 2b. HOUR
1400 M | | |
| 3. SEX
M. | | | 4. RACE
W. | | | 5. DATE OF BIRTH
Feb 23 1904 | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. COUNTY OF DEATH
Montgomery | | | 6. AGE (In years lost birthday)
65 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Potomac Valley Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
lawyer | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Rockville | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
735 Monroe St | | | 12b. KIND OF BUSINESS OR INDUSTRY
Rockville Md. | | |
| 14. FATHER'S NAME
First Middle Last
Irene Cyr | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Elodie Pinette | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
Yes | | | 16b. SOCIAL SECURITY NO.
314-26-5797 | | | 17. INFORMANT
Marie F Cyr | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia - RLL
481 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebral atrophy - | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-28 , 19 65 , to 2-23-69 , 19 69 , that (H) (we) last saw the deceased alive on 2-23 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
John S. Saia | | 22c. DATE SIGNED
2-23-69 | | 22d. PHYSICIAN'S NAME (Type)
JOHN S. SAIA MD | | | | |
| 22e. ADDRESS
809 Viers Mill Rd Rockville | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-26-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring Mont. Md | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | | | 25a. REC'D BY REGISTRAR
DATE FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

03883

03883

23 APR 1964

W

1/1

Montgomery

ACU

London

Between Valley Road and

Rockville

Montgomery, Rockville X

Yes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|---------------------|--|---|---|---|---|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>Chiniero</i> | | | 2a. DATE KNOWN OF DEATH
Month <i>Feb</i> Day <i>9</i> Year <i>1969</i> | | | 2b. HOUR
<i>3:30</i> P.M. | | | | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
<i>Jan 26, 1897</i> | 6. AGE (in years last birthday)
<i>72</i> YRS. | IF UNDER 1 YEAR
MONTHS <i>0</i> DAYS <i>0</i> | IF UNDER 24 HRS.
HOURS <i>0</i> MIN. <i>0</i> | 2c. DATE PRONOUNCED DEAD
Month <i>Feb</i> Day <i>9</i> Year <i>1969</i> | | 2d. HOUR
<i>4:00</i> P.M. | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Italy</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S.</i> | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Potomac</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>10020 Kenilworth Dr.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>House Builder</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Building</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY
<i>Montgomery Silver Spring</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>2208 Colston Drive</i> | | |
| 14. FATHER'S NAME
First <i>Paolo</i> Middle <i>Grazia</i> Last <i>D'Aprile</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Grazia</i> Middle <i>De Mutti</i> Last <i>Mutis</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
<i>078-07-6605</i> | |
| 17. INFORMANT
<i>Brother</i> | | | ADDRESS
<i>Same as Item 13</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
<i>411.9</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
<i>Feb 9, 1969</i> | | |
| EXAMINER'S NAME (Type)
<i>JOHN G. BALL</i> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>2-25-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cimitero Raiano</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Province Aquila, Italy</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | | 25a. REC'D BY REGISTRAR
<i>FEB 17 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

53330

53330

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02553

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Vivian Imogene Davis | | | 2a. DATE OF DEATH
Month Day Year
February 6 1969 | | 2b. HOUR A
11:10^{PM} |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
22 February 1919 | | 6. AGE (In years lost birthday)
49 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Georgia | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Georgia | 13b. COUNTY
Summerville | 13c. CITY OR TOWN
Summerville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
100 Espy Street | |
| 14. FATHER'S NAME First Middle Last
Paul Hawkins | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nettie Humphrey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
Not Available | | 17. INFORMANT Address
Bethesda, Maryland 20014
The Medical Records, The Clinical Center, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gram negative sepsis
174 X
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic adenocarcinoma of the breast
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 Hours
10 Months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (a) (this hospital) attended the deceased from 17 January , 19 69 , to 6 Feb. , 19 69 , that it (we) last saw the deceased alive on 6 February , 19 69 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Sherrard L. Hayes, M. D. | | | | | 22c. DATE SIGNED
6 February 1969 |
| 22d. PHYSICIAN'S NAME (Type)
Sherrard L. Hayes, M. D. | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial/Removal | | 23b. DATE
2/7/69 | 23c. NAME OF CEMETERY OR CREMATORY
Memory Gardens, | | 23d. LOCATION (City or Town) (County) (State)
Rome, Georgia |
| 24. FUNERAL DIRECTOR
Jos. Gawler's Sons, 5130 | | | 25a. REC'D BY REGISTRAR
FEB 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

08553

EXHIBIT OF DEATH

08553

1950

1950

White

Female

Monterey

USA

Georgia

White

The Clinical Center, NIH

Atlanta

1950

Atlanta

Atlanta

White

Male

Male

born in 1901, the Clinical Center, NIH

not visible

on 1950

on 1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|---|---|--|---|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 025559 CERTIFICATE OF DEATH 025554 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Helan M Delaney</i> | | | 2a. DATE OF DEATH
Month <i>Feb</i> Day <i>25</i> Year <i>69</i> | | | 2b. HOUR
<i>5:30</i> P.M. | | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>7-11-1890</i> | | 6. AGE (In years
last birthday)
<i>78</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Wheaton</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>Wheaton Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Wheaton</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>2712 Elmore Street</i> | |
| 14. FATHER'S NAME First Middle Last
<i>James H. Delaney</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Margaret A Ryan</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>061-10-1460</i> | | 17. INFORMANT
<i>Dr's Chart</i> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>PNEUMONIA, RIGHT LOWER LOBE</i>
<i>4409</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>GENERALIZED ARTERIOSCLEROSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>2 DAYS</i>
<i>10 YEARS</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>SENILE PSYCHOSIS, DECUBITUS ULCERS</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>FEB 25</i> , 19 <i>69</i> , that (I) (we) last
saw the deceased alive on <i>FEB 25</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Edward G. Beeman</i> M.D.
DEGREE | | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>FEB 25, 1969</i> | | | | |
| 22d. PHYSICIAN'S
NAME (Type) <i>EDWARD A. BEEMAN</i> | | | | 22e. ADDRESS
<i>1015 SPRING ST.
SILVER SPRING MD 20910</i> | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>2-27-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>FT LINCOLN</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>BLADENS BURG, MARYLAND</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Thomas J. Callers</i> | | | | ADDRESS
<i>500 University Blvd
Silver Spring, Md</i> | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 28 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

92-52

0522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

Cleared by Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02560

02555

| | | | | | | | | | | |
|---|--|-------------------------------------|--|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Everett Earl Delph | | | 2a. DATE OF DEATH
Month Day Year
2 23 69 | | | 2b. HOUR
M | | | | |
| 3. SEX
male | | 4. RACE
Cauc | | 5. DATE OF BIRTH
1/31/10 | | 6. AGE (In years
last birthday)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Salesman | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Oil Co. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Sil.Spg. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1215 Brantford Ave. | |
| 14. FATHER'S NAME First Middle Last
John -- Delph | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ann (Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW 2 | | | 16b. SOCIAL SECURITY NO.
401-01-2380 | | 17. INFORMANT
Thelma Delph | | | Address
1215 Brantford Ave. SS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CORONARY THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC HEART DISEASE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HOUR
INDEFINITE | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov, 1968, to 2/23, 1969, that (I) (we) last saw the deceased alive on 2/23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence D. Marcus | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/23/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Lawrence D. Marcus M.D. | | | 22e. ADDRESS
1111 Spring Street, Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
2-27-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Salem Church Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Romney, West Virginia | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | ADDRESS
Sil.Spr.Md. | | 25a. RECD BY REGISTRAR
DATE FEB 28 1969 | | 25b. REGISTRAR'S SIGNATURE
James J. Judge | | | |

02552

02550



101-10-112

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02561

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02558

| | | | | | | | | | |
|---|-------------------------|--|---|---|--------------------------------|---|--|--|--|
| 1. DECEASED NAME
(Type or Print) DAVE | | First Middle Last | | DENABURG | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 2 15 1969 | | 2b. HOUR 5:30 P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
11-17-1907 | 6. AGE (In years last birthday)
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month 2 Day 15 Year 1969 | | 2d. HOUR 5:30 P.M. | |
| 7a. BIRTHPLACE (State or foreign country)
Md; Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
8103 Eastern Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retail Store Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Liquor | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil Spg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8103 Eastern Avenue | |
| 14. FATHER'S NAME
Israel | | First Middle Last
Denaburg | | 15. MOTHER'S MAIDEN NAME
Frieda | | First Middle Last
Zabotnich | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
unknown | | 17. INFORMANT
Bertha Denaburg, same as 13 above | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF A
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden A. Peap
EXAMINER'S NAME (Type) | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
Feb. 15, 1969 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb 17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Falls Church, Va. | | | |
| 24. FUNERAL DIRECTOR
Goldberg Funeral Home | | | | ADDRESS
4217 9th Street N.W. | | 25a. REC'D BY REGISTRAR
FEB 19 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 02562 | | | | | | 02557 | | | | | |
| 1. DECEASED-NAME (Type or print) Louis C Dismer | | | | | | 2a. DATE OF DEATH February 8 1969 | | | | 2b. HOUR 7:00 M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Dec. 6, 1885 | | 6. AGE (In years last birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Wash. DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and number) 2102 Forest Glen Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Realtor | | 12b. KIND OF BUSINESS OR INDUSTRY Real Estate | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2102-Forest Glen Road | | | |
| 14. FATHER'S NAME First Charles W. Middle Dismer Last Dismer | | | | 15. MOTHER'S MAIDEN NAME First Caroline Middle -- Last Heine | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) -- | | 16b. SOCIAL SECURITY NO. 577-03-6979 A | | 17. INFORMANT Address Sil. Spr., Md.
Mrs. Rosa Houck Dismer 2102 Forest Glen Rd | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 185 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) breast cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) breast cancer of ductal type | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
long
4 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1962 to 2-8-69 , 19 69 , that (I) (we) lost sow the deceased alive on Jan 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John S. Rogers | | 22c. DATE SIGNED Feb 9 1969 | | 22d. PHYSICIAN'S NAME (Type) John S. Rogers | | 22e. ADDRESS 1515 Seminary Rd. Silver Spring, Md. | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-12-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION (City or Town) Washington, D. C. (County) (State) | | 25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc. | | | |
| 23e. FUNERAL DIRECTOR C. Glen Carter | | 23f. ADDRESS Sil. Spr., Md. | | 23g. DATE FEB 14 1969 | | 23h. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc. | | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02563

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02558

| | | | | | | | | | | | | | |
|---|--|-------------------|---|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Annie | | | First Middle Last Dobkin | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Feb. 23 1969 | | | 2b. HOUR 5:30 P.M. | | | | |
| 3. SEX Fe. | | 4. RACE W. | | 5. DATE OF BIRTH APR 11, 1970 | | 6. AGE (In years last birthday) 98 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year Feb. 23 1969 | | 2d. HOUR 5:30 P.M. | |
| 7a. BIRTHPLACE (State or foreign country) RUSSIA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH Chevy Chase | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beth Silver Spring Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Mr. Chevy Chase | | | 13b. COUNTY MONT. | | | 13c. CITY OR TOWN CHEVY CHASE | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 9101 LeVelle Dr. | | |
| 14. FATHER'S NAME Abraham | | | First Middle Last Barskin | | | 15. MOTHER'S MAIDEN NAME UNK. | | | First Middle Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 220-44-0143 | | | 17. INFORMANT HARRY DOBKIN | | | ADDRESS 1530 Locust Rd NW | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4124
(b) Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Infiltrate of lungs | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | EXAMINER'S NAME (Type) JOHN G. BALL, MD | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED Feb. 23, 1969 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE FEB 25, 69 | | 23c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL CEM. | | | | 23d. LOCATION (City or Town) (County) (State) OXON HILL MD. | | | |
| 24. FUNERAL DIRECTOR Goldberg Fun'l Home | | | | | | ADDRESS 4217 9th St. NW Wash | | 25a. REC'D BY REGISTRAR FEB 27 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

0320

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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| <div>02564</div> <div> <div>02559</div> <div>02559</div> </div> | | | | | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|---|---|--|--|--|----------------------------|--|
| 1. DECEASED-NAME
(Type or Print) James Edward Dodd | | | | | | 2a. DATE KNOWN OF DEATH
Month 2 Day 9 Year 1969 | | | | | | 2b. HOUR
6:55 AM | | | |
| 3. SEX
Male | | 4. RACE
Cauc | | 5. DATE OF BIRTH
8/12/93 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | 2c. DATE PRONOUNCED DEAD
Month 2 Day 9 Year 1969 | | 2d. HOUR
6:55 AM | |
| 7a. BIRTHPLACE (State or foreign country)
England | | | 7b. CITIZEN OF WHAT COUNTRY?
Canadian | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Insurance Agent | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | | | 13b. COUNTY
Montgomery Sil.Spg. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
9311 Wire Ave. | | | | | |
| 14. FATHER'S NAME
First Mark Middle _____ Last Dodd | | | | | | 15. MOTHER'S MAIDEN NAME
First _____ Middle Mary Last Dodd | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Alan Dodd ADDRESS
14533 Perrywood Dr. Burton | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap
EXAMINER'S NAME (Type) BELODEN R. REAP, M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
Feb. 9, 1969 | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE
Feb. 12, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | | | | | | | |
| 24. FUNERAL DIRECTOR
Arthur Walters | | | | | | ADDRESS
254 Carroll St. N.W. Wash. D.C. | | 25. REC'D BY REGISTRAR
FEB 13 1969 | | 26. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---------|--|------------------|------------------------------------|--|---------------------------------|--|--|------------------------|--|
| 02565 CERTIFICATE OF DEATH 02560 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JAMES LORENZO DOMINICK | | | | | | FEBRUARY 7, 1969 | | | 6:45 P | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years less birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| MALE | | CAUC | | 3 JUNE 1916 | | | 52 YRS. | | MONTHS DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| S. CAROLINA | | | USA | | | | | | MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA, MD. | | | NAVAL HOSPITAL | | | NAVY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| S. C. | | | | | | GREENWOOD | | | | RT 1, BX 94 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| BEN TILMAN DOMINICK | | | KATE STOCKMAN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| YES | | | 224-50-1712 | | | ENNA S. DOMINICK, RT 1, BX 94, GREENWOOD, S.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA | | | | | | | | | | | |
| 1451 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE SOFT PALATE AND TONGUE | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) WITH METASTASIS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | JAN | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10AM, 7 FEB 1969, to 6:45, FEB 19 69, that (I) (we) last saw the deceased alive on 7 FEB 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE L. J. MERVIS | | | | | | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) L. J. MERVIS | | | | | | | | | 22e. ADDRESS | | |
| | | | | | | | | | NAVAL HOSPITAL, BETHESDA, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | | 2/12/69 | | REHOBATH METHODIST CHURCH | | | GREENWOOD, S. C. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| JOSEPH GAWLER AND SON 5130 WISC. AVE WDC | | | | | | DATE FEB 13 1969 | | [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30A REV. 1/68

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02566

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02561

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Muriel M. Drew | | 2a. DATE OF DEATH
Month Day Year
February 26 1969 | | 2b. HOUR P
2:15 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10 January 1921 | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (In years last birthday)
48 YRS. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Falls Church | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7405 Venice Street | | | |
| 14. FATHER'S NAME First Middle Last
Arthur McGuire | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Aldrich | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
059-14-2660 | | 17. INFORMANT
Bethesda, Maryland 20014
The Medical Records, The Clinical Center, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema and Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Islet Cell Carcinoma of Pancreas
DUE TO, OR AS A CONSEQUENCE OF
(c)
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 Minutes
2 Years |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 18 December 1968 , to 26 Feb. 1969 , that (we) last saw the deceased alive on 26 February 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Phillip Gorden MD | | | | 22c. DATE SIGNED
26 February 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Phillip Gorden, M.D. | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Tran-Burial | | 23b. DATE
2/1/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Moravian Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Staten Island, NY | | 24. FUNERAL DIRECTOR
Falls Church Funeral Home, Falls Church, Va. | | | |
| 25a. REC'D BY REGISTRAR
FEB 28 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Richard J. Judge | |

Wills Church General Home, 701 E. Church St.,
1102 W. Broad St.
Greenville Community

D) FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner 1-10-69/2308 MZ Lh H

VR A15
45M - 1169

| <div style="display: flex; justify-content: space-between;"> 02567 MARYLAND STATE DEPARTMENT OF HEALTH 02562 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Charles B. Duckett | | | | 2a. DATE OF DEATH
Month Feb. Day 10 Year 1969 | | | | 2b. HOUR
12:30 M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
May 7, 1892 | | 6. AGE (In years last birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
8911 Sudbury Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Shop Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8911 Sudbury Road | |
| 14. FATHER'S NAME First Alfred Middle M. Last Duckett | | | | 15. MOTHER'S MAIDEN NAME First Minnie Middle -- Last Lee | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) -- | | 16b. SOCIAL SECURITY NO.
578-14-7308 | | 17. INFORMANT Address Sil. Spr., Md.
B Catherine J. Duckett 8911 Sudbury Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min
13 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-9-1969 to 1-10-1969 , that (I) (we) last saw the deceased alive on 1-9-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Lester W. Harris M.D. | | | | DEGREE DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-10-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
HARRIS | | | | 22e. ADDRESS
507 Northwest Dr Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
2-13-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Pr. Geos. Md. | | | |
| 23e. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | ADDRESS
Sil. Spr., Md. | | 25a. REC'D BY REGISTRAR
FEB 17 1969 | | 25b. REGISTRAR'S SIGNATURE
William A. Judge | | | |

02550

CERTIFICATE OF DEATH

02550

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 11-68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02568

02563

| | | | | | | | | | | | |
|--|--|--|----------------|---|--|---|---|--|--|---|-------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month <u>2</u> Day <u>5</u> Year <u>69</u> | | 2b. HOUR
<u>6:45</u> M | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Wh.</u> | | 5. DATE OF BIRTH
<u>2-5-69</u> | | 6. AGE (in years
last birthday)
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
<u>md.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>mont.</u> | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<u>Holy Cross</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <u>md</u> | | 13b. COUNTY
<u>Mont.</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>135 37 Georgia Ave.</u> | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| | | <u>Charles</u> | <u>Clayton</u> | <u>Edwards</u> | | | <u>Wilma</u> | <u>Ann</u> | <u>Blair</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mother</u> | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u>
<u>7762</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-5-69</u> , to <u>2-5-69</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>2-5-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Raymond Gibbons M.D.</u> | | | | | DEGREE | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2-5-69</u> | | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>Raymond Gibbons M.D.</u> | | | | | 22e. ADDRESS
<u>2401 Blue Ridge Ave. Wheaton, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>2/8/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery</u> | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| | | | | | | <u>Silver Spring, Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home 1331 Rockville Pike</u> | | | | | ADDRESS
<u>Rockville, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 13 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

15588

15588



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02569 | | | | | | | | | | 02564 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) <u>RUDOLFS (and)</u> | | | | | First Middle Last | | | | | 2a. DATE OF DEATH
Month <u>2</u> Day <u>1</u> Year <u>69</u> | | | | | 2b. HOUR
<u>1:50</u> P.M. | | | | | | | | | |
| 3. SEX
<u>male</u> | | | | | 4. RACE
<u>WHITE</u> | | | | | 5. DATE OF BIRTH
<u>9-16-92</u> | | | | | 6. AGE (In years last birthday)
<u>76</u> YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Latvia</u> | | | | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Holy Cross Hospital</u> | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Physician</u> | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Medical</u> | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>md.</u> | | | | | 13b. COUNTY
<u>Montgomery</u> | | | | | 13c. CITY OR TOWN
<u>Wheaton</u> | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
<u>12713 Connecticut Avenue</u> | | | | |
| 14. FATHER'S NAME
First Middle Last
<u>(Unknown)</u> | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<u>(Unknown)</u> | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>no</u> | | | | | 16b. SOCIAL SECURITY NO.
<u>105-26-4008</u> | | | | | 17. INFORMANT
<u>Dzidna G. Williams</u> | | | | | Address
<u>Maryland 12713 Conn. Ave. Wheaton</u> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
<u>4319</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Coronary Artery Disease Since</u>
(c) <u>Generalized Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Terminal bronchopneumonia</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 Days</u>
<u>Years</u>
<u>Years</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 <u>69</u> | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10/66</u> , to <u>2/1/69</u> , that (I) (we) lost the deceased alive on <u>2/1/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John J. Curry</u> | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>2/2/69</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>John J. Curry, M.D.</u> | | | | | | | | | | 22e. ADDRESS
<u>9801 Georgia Ave Silver Spring</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial Cremation 2-4-1969</u> | | | | | 23b. DATE
<u>2-4-1969</u> | | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Lincoln Crematory</u> | | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland, Prince Georges, Md.</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | | | | | | | | ADDRESS
<u>Sil. Spr., Md.</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>7 1969</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Thomas A. Judge</u> | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02570

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02565

| | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|---|---|--------------------------------|--|
| 1. DECEASED-NAME
(Type or Print)
CLARA | | | First Middle Last
EISELE | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> Month Day Year
Feb. 27, 1969 | | | 2b. HOUR OF DEATH
6:45 P M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1-11-1872 | | 6. AGE (In years last birthday)
97 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Iowa | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Potomac Valley Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Bethesda | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
7800 Glenbrook Rd. | | | 14. FATHER'S NAME
First Middle Last
Andrew Eichhorn | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Louisa (Unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
None | | | 17. INFORMANT
Daug.-in-law | | | ADDRESS
Mrs. Mary C. Eisele Same as Item 13. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball
EXAMINER'S NAME (Type)
JOHN G. BALL | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) Bethesda, Md. | | | | | |
| 22b. DATE SIGNED
Feb. 28, 1969 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | 23b. DATE
2-28-69 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | |
| 23d. LOCATION (City or Town)
Suitland, Maryland | | | | 23e. REC'D BY REGISTRAR
MAR 4 1969 | | | | 23f. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | | | | | | |

07280

Environ Biol Fish (2015) 98:1035–1045

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02571

02566

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) First Mary Middle Blanch Last Ekin | | | 2a. DATE OF DEATH
Month Feb Day 17 Year 69 | | 2b. HOUR
11 P M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
9/12/1877 | | 6. AGE (In years lost birthday)
91 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Penn. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
MONT. | | |
| 10. CITY OR TOWN OF DEATH
Kennsington | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Kennsington Gardens | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
R.N. retired | 12b. KIND OF BUSINESS OR INDUSTRY
NURSE |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY
MONT. | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
1917 N. Mansion Dr. |
| 14. FATHER'S NAME First Robert Middle F. Last Ekin | | | 15. MOTHER'S MAIDEN NAME First Mary Jane Middle Brennehan Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
220-48-7904 | 17. INFORMANT
FAMILY RECORDS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
437.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cerebral vascular
DUE TO, OR AS A CONSEQUENCE OF (c) diabetes | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
20 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1954 , to Feb 17, 1969 , that (I) (we) lost the deceased alive on Feb 17, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | 22c. DATE SIGNED
2/17/69 | | 22d. PHYSICIAN'S NAME (Type)
D. F. Kreuzburg | |
| 22e. ADDRESS
7852 16th St NW Wash DC | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
FEB. 18, 1969 | 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
PIKESVILLE, MD. |
| 24. FUNERAL DIRECTOR
John Barros Sons | | ADDRESS
Louisa Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1969 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

00320

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RECEIVED

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY

VR A15ME (5)
10M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 02572 MARYLAND STATE DEPARTMENT OF HEALTH 02567 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|------------------|--|---|--|---|--|--|--|-----------------------------------|--|--|
| 1. DECEASED-NAME (Type or Print) <u>JENNIE</u> First <u>R.</u> Middle <u>Ellis</u> Last | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>Feb</u> Day <u>6</u> Year <u>1969</u> | | | 2b. HOUR <u>9:30</u> M | | |
| 3. SEX <u>7</u> | 4. RACE <u>W</u> | 5. DATE OF BIRTH <u>6/5/1889</u> | 6. AGE (In years last birthday) <u>79</u> YRS. | IF UNDER 1 YEAR
MONTHS <u>8</u> DAYS <u>1</u> | IF UNDER 24 HRS
HOURS <u></u> MIN. <u></u> | 2c. DATE PRONOUNCED DEAD Month <u>Feb</u> Day <u>6</u> Year <u>1969</u> | | | 2d. HOUR <u>9:30</u> M | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> | | | Md | | |
| 10. CITY OR TOWN OF DEATH <u>Kensington</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE <u>Maryland</u> | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Bethesda</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>7900 Custer Road</u> | | | |
| 14. FATHER'S NAME First <u>Theodore</u> Middle <u></u> Last <u>Raymond</u> | | | 15. MOTHER'S MAIDEN NAME First <u>Ida</u> Middle <u>E.</u> Last <u>Curtis</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>344-01-0995</u> | | 17. INFORMANT <u>Mrs. Colette E. Hanks</u> ADDRESS <u>7900-Custer Rd., Bethesda, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerosis, generalized, severe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u></u> P.M. <u></u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>Feb 7, 1969</u> | | | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXX</u> | | 23b. DATE <u>2-10-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u> | | 23d. LOCATION (City or Town) <u>Salem</u> (County) <u>Ill.</u> (State) <u></u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>7557-Wisconsin Ave., Bethesda, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>FEB 13 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.
 FROM THE COMMISSIONER, BUREAU OF INTERNAL REVENUE, WASHINGTON, D. C.
 SUBJECT: [Illegible]

Reference is made to your letter of the 10th day of September, 1930, in relation to the above subject.
 The Bureau has no objection to the proposed action, and the same may be taken.
 Very respectfully,
 [Illegible Signature]

Very truly yours,
 [Illegible Signature]
 [Illegible Title]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Bertha | | | Middle
Ann | | | Last
Embrey | | | 2a. DATE OF DEATH
Month
February | | | Day
14 | | | Year
1969 | | | 2b. HOUR
6:30 | | | M
A | | |
| 3. SEX
F | | | 4. RACE
W | | | 5. DATE OF BIRTH
March 10, 1874 | | | 6. AGE (In years
last birthday)
94 | | | 7. YRS. | | | 8. IF UNDER 1 YEAR
MONTHS | | | 9. IF UNDER 24 HRS.
HOURS | | | 10. MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Vermont | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | 10. CITY OR TOWN OF DEATH
Gaithersburg | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Asbury Methodist Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Virginia | | | 13b. COUNTY
Washington, D.C. | | | 13c. CITY OR TOWN
Washington, D.C. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
3823-25th Place, N.E. | | | 14. FATHER'S NAME
First
Jacob | | | 15. MOTHER'S MAIDEN NAME
First
Annis | | | 16. MOTHER'S MAIDEN NAME
Middle
D. | | | 17. MOTHER'S MAIDEN NAME
Last
Stevens | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | | 16b. SOCIAL SECURITY NO.
212-54-7173-T | | | 17. INFORMANT
Asbury Methodist Home, Gaithersburg, Md. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
485X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 days | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | 22a. I certify that (I) (this hospital) attended the deceased from <u>3/63</u> , 19 <u>63</u> , to <u>2/14/69</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>2/14/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE
<u>Ernest C. Gartner</u> | | | 22c. DATE SIGNED
2/14/69 | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | 22e. ADDRESS | | | 22f. ADDRESS | | | 22g. ADDRESS | | | 22h. ADDRESS | | | 22i. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
Burial. 2-17-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Manassas Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Manassas Va | | | 24. FUNERAL DIRECTOR
Ernest C. Gartner | | | 25. REGISTRATION BY REGISTRAR
FEB 17 1969 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |

81208

81208

DATE: 10/10/50

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/50

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/50

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/50

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

Cleared with medical examiner - Dr. B. Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02574

02569

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Sarah C. England | | | 2a. DATE OF DEATH
Month February Day 6 Year 1969 | | | 2b. HOUR
8:30 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
6 JUNE 1886 | | 6. AGE (In years lost birthday)
82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
422 ST. LAWRENCE DR. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HW | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. CITY OR TOWN
SILVER SPRING | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
422 ST. LAWRENCE DR. | |
| 14. FATHER'S NAME First Middle Last
PETER CONVERY | | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARY SLATTERY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not of unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
236-05-8891 | | 17. INFORMANT Address
MRS. MABEL COFFMAN 132, 6, c, d e above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary thrombosis
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Generalized and coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several hours
Many years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to Feb. 6 , 1969, that (I) (we) lost the deceased on January 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bennet A. Porter, Jr., M.D. | | | | 22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22d. DATE SIGNED
February 6, 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Bennet A. Porter, Jr., M.D. | | | | 22e. ADDRESS
9301 Coleridge Rd., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
8 FEB. 1969 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
MAN WEST VIRGINIA | |
| 24. FUNERAL DIRECTOR
RINALDI FUNERAL HOME, INC. | | | | 25a. REC'D BY REGISTRAR
7400 GEORGETOWN AVE. N.W. WASHINGTON, DC 20012 | | 25b. REGISTRAR'S SIGNATURE
FEB 10 1969 | |

MEDICAL CERTIFICATION

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10130 10 022117

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
ERIC | | Middle | | Last
ENGLUND | | 2a. DATE OF DEATH
Feb. Month 24, Day 1969 | | 2b. HOUR
3:38 PM |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
4-1-1893 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Sweden | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | Id. |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Randolph Hills Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Economist | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3024 Tilden Street N.W. | | |
| 14. FATHER'S NAME | | First
Olaf | | Middle
Peter | | Last
Englund | | 15. MOTHER'S MAIDEN NAME | | First
Marie
Middle
Haggblad
Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
Yes | | (If yes give year or dates of service)
W.W. I | | 16b. SOCIAL SECURITY NO.
579-56-8885 | | 17. INFORMANT
Mrs. Gladys Englund, Widow, same as #13 | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cerebral Thrombosis</u>
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>arteriosclerotic cerebral</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | 2 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
2 or more previous cerebrovascular Thromboses | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 1964</u> to <u>THE PRESENT</u> that (I) (we) last saw the deceased alive on <u>Feb-18 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edward W. Youngblood</u> | | 22c. DATE SIGNED
February 24, 1969 | | 22d. PHYSICIAN'S NAME (Type)
E. YOUNGBLOOD | | 22e. ADDRESS
WASHINGTON CLINIC | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
2-27-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State) Id.
Suitland, Prince Georges Co., | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | 25a. REC'D BY REGISTRAR
FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages read 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>02576</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02571</div> | | | | | | | | | | | |
|---|---------|------------------|--|-----------------|------|--|------|---------------------------|---|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | | 2b. HOUR | | |
| RUTH | | | NIN | | | EPSTEIN | | | <input checked="" type="checkbox"/> Month Day Year
<input type="checkbox"/> Feb 15 1969 4:33AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | White | Feb. 22, 1898 | 70 YRS. | MONTHS | DAYS | HOURS | MIN. | Feb. 15
Month Day Year | | 169 4:33A | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| New Jersey | | | U.S.A. | | | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | | | Washington San. & Hospital | | | housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | | Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1401 Blair Mill Rd. #1005 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| XXXXXX Max | | | Radin | | | Bayla | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | | | | Mrs. Rhoda Gould - daughter- N.Y. | | | 61 Jane ST.-N.Y.C. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4121 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Acute Coronary Insufficiency | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Coronary Artery Heart Disease | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Essential Hypertension | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| ACTUAL SIGNATURE | | | M.D. | | | DEPUTY MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (Type) | | | Belden A. Reap | | | ADDRESS (Street, city, town or county) | | | Feb. 15, 1969 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 2-17/69 | | | Montifore Cemetery | | | Brooklyn, N.Y. | | |
| 24. FUNERAL DIRECTOR | | | B. Naugbuck | | | ADDRESS 3501-145th NW | | | 25a. REC'D BY REGISTRAR | | |
| | | | | | | WASH DC | | | FEB 19 1969 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | | | | | Charles Judge | | |

258

17530

2. 2. 2. 2.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|
| Item 8 Film 409
2/21/69 kl 02577 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
02577 | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print)
First Middle Last
Nathan none Fanaroff | | | | | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 2 9 69 11:20A
2b. HOUR | | | | | | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
10-10-87 | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 2 - Day 9 Year 1969
2d. HOUR 11:28 A.M. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | | | 7b. CITIZEN OF WHAT COUNTRY?
US | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San & Hosp | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Merchant | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY Mont. | | | | 13c. CITY OR TOWN Bethesda | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8006 Whittier Blvd | | | | | |
| 14. FATHER'S NAME
First Middle Last
Louis Fanaroff | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Fanaroff | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
579-32-2105 | | | | 17. INFORMANT
Louis Fanaroff | | | | ADDRESS
7101 Loch Lomond Beth. md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonitis, Bilateral
486X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| Diabetes Mellitus; Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR 7:00 P.M. 1-10-69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Deceased fell at home and 7x left hip | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
8006 Whittier Blvd, Bethesda, Montg, Md | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | | M.D.
BELDEN R. REAP, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
Feb. 9, 1969 | | | | | | | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, City, County, or State)
Washington, D.C. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
Feb. 10/69 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Elesavetgrad Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | | | | |
| 24. FUNERAL DIRECTOR
Bernard Danzansky & Sons | | | | ADDRESS
3501 14th St. N.W. | | | | 25a. REC'D BY REGISTRAR
DATE
FEB 13 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | | | | | |

FOR STATE
HEALTH DEPT



05275

05275

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

| | |
|------------|--------------------|
| NAME | JOHN J. DAVIS |
| AGE | 35 |
| SEX | M |
| RACE | W |
| RELIGION | C |
| EDUCATION | H |
| OCCUPATION | DRIVER |
| RESIDENCE | 1234 E. MAIN ST. |
| CITY | DALLAS |
| STATE | TEXAS |
| ZIP | 75201 |
| DATE | 10-15-68 |
| TIME | 10:00 AM |
| BY | DR. J. H. SMITH |
| FOR | PHYSICIAN |
| REMARKS | ALL SYSTEMS NORMAL |

10-15-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02578

02573

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) Gladys B. Fiedler | | | 2a. DATE OF DEATH
Month 2 Day 26 Year 69 | | | 2b. HOUR P
Min 12:45 | |
| 3. SEX
Female | | 4. RACE
W | | 5. DATE OF BIRTH
7-14-90 | | 6. AGE (In years
lost birthday)
78 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) Kansas | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Silver Spr. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First B Middle FRANKLIN Last Boyle | | 15. MOTHER'S MAIDEN NAME First Cella Middle J Last Miller | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Albert G Fielder | | | | Address Silver Spring, Md
3383 S. Leisure World Blvd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4123 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Emphysema, Bronchopneumonia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13 , 19 67 , to 2/26 , 19 69 , that (II) (we) last
saw the deceased alive, on 2/25 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above (II) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Allan B. Cohan, M.D. M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING
PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/27/69 | | | |
| 22d. PHYSICIAN'S
NAME (Type) Allan B. Cohan, M.D. | | | | 22e. ADDRESS
13515 Georgia Ave., Sil. Spr., Md. | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
2-27-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Southland Pa Co MD | |
| 24. FUNERAL DIRECTOR
RA PUMPHREY | | ADDRESS
7557 Wisconsin Ave Bethesda. | | 25a. REC'D BY REGISTRAR
DATE FEB 28 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

05218

05218

CENTRAL OF GEORGIA

Montgomery County

W.S.A.

Female

W

Silver Spring, Md. Holy Cross Hospital

Home. Bill. 05218

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P |
| Kenneth Allen Flowers | | | | | | February 5 1969 | | | 2:30 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| Male | | White | | 29 December 1965 | | | 3 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| District of Columbia | | | USA | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | | The Clinical Center, NIH | | | Child | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | | Prince Georges | | Suitland | | YES | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Ernest Flowers | | | Patricia Tucker | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | None | | The Medical Record The Clinical Center, NIH, Bethesda, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wound dehiscence, evisceration and systemic /</u> | | | | | | | | | 2 - 3 days |
| 2040 DUE TO, OR AS A CONSEQUENCE OF <u>Mild subdural hemorrhage - terminal</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Perforated colon 1/23/69, gastrointestinal bleeding 1/26/69</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute lymphocytic leukemia</u> | | | | | | | | | 21 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 1/23/69, 1/26/69 | | Perforated colon Gastrointestinal bleeding | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>22 January 1969</u> , to <u>5 Feb. 1969</u> , that (X) (we) last saw the deceased alive on <u>5 February 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Peter J. Deckers MD</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED <u>February 5, 1969</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>Peter J. Deckers, M.D.</u> | | | | 22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Feb 9, 1969 | | Mt. Carmel Cemetery | | Middletown, Fred, Co. Va. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>John C. Everly Alexandria, Va.</u> | | | | FEB 10 1969 | | <u>William J. Jones</u> | | | |

MEDICAL CERTIFICATION

4280

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02580

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02575

| | | | | | | | | | | |
|---|----------------------|---|--|---|---|--|---|----------------------------------|---|-----------------|
| 1. DECEASED-NAME
(Type or Print) <i>John H. Forsberg Jr.</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Feb</i> Day <i>2</i> Year <i>1969</i> | | | 2b. HOUR <i>4:15</i> M | | | | |
| 3. SEX <i>male</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH <i>8/14/21</i> | 6. AGE (in years last birthday) <i>47</i> YRS | IF UNDER 1 YEAR
MONTHS <i>0</i> DAYS <i>0</i> | IF UNDER 24 HRS
HOURS <i>0</i> MIN. <i>0</i> | 2c. DATE PRONOUNCED DEAD
Month <i>Feb</i> Day <i>2</i> Year <i>1969</i> | | | 2d. HOUR <i>4:45</i> M | |
| 7a. BIRTHPLACE (State or foreign country) <i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i> | | | 13b. COUNTY <i>Mont. Co.</i> | | 13c. CITY OR TOWN <i>Potomac</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>11033 Powder Horn</i> | |
| 14. FATHER'S NAME First <i>John</i> Middle <i>H.</i> Last <i>Forsberg</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i>McDonald</i> Last <i>McDonald</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> | | | 16b. SOCIAL SECURITY NO. <i>109-182675</i> | | 17. INFORMANT <i>Eileen B. Forsberg</i> | | | ADDRESS <i>11033 Powder Horn</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Location + contusion of Brain and</i>
<i>885x</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Fracture of skull</i>
(c) <i>Trauma from fall</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 days</i>
<i>4 days</i>
<i>4 days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>Jan 29, 1969</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Craniotomy</i> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>Jan 29 1969</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fallen on ice inside way at home striking Head.</i> | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i> | | 21f. LOCATION Street or R.F.D. No. <i>11033 Powder Horn</i> | | City or Town <i>DA. Potomac</i> | | County <i>Montgomery</i> | | State <i>MD</i> |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Feb 2, 1969</i> | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>2-5-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cemetery - Baltimore, Maryland</i> | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| 24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave. N.W., Wash., D.C., 20016</i> | | | | 25. REGD BY REGISTRAR <i>6</i> 1969 | | 25b. YEAR OF REGISTRATION <i>1969</i> | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 02581 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02576 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Lillian L. Fowler | | | | | | | | | | Feb. 7 1969 | | | | | | | | | | 9:45 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH Nov. 21 1891 | | | | | | | | | | 6. AGE (In years lost birthday) 77 YRS. 2 17 | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Penna | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nursing Home | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Own home | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 14236 Chadwick Lane | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last William B. Hathrop | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lydia M. Westler | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. 178-07-5360 | | | | | | | | | | 17. INFORMANT Address Nursing Home Records 12325 New Hampshire Ave | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA & coma
4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Aseptic
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes Mellitus, CHF. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mos.
indef. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 1967, to Feb. 1969, that (I) (we) last saw the deceased alive on Feb. 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Mari Schuecker, M.D. DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE/SIGNED 2/7/69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS 911 Silver Spring Ave. - S.S. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE FEB. 10, 1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) LANSDOWNE, PENNA. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR M.W. HYSONG CO. INC. ADDRESS 1300 N ST. N.W. Wash. D.C. | | | | | | | | | | 25a. REGISTRY FEB 10 1969 REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

US.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 151
10M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02582

02577

| | | | | | | | | | |
|---|---------------------|--|---|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Lawrence E. Frankensfield</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>24</i> Year <i>1969</i> | | | 2b. HOUR <i>M</i> | | | |
| 3. SEX <i>M</i> | 4. RACE <i>Cauc</i> | 5. DATE OF BIRTH <i>7/20/1906</i> | 6. AGE (In years last birthday) <i>62</i> YRS. | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS.
HOURS <i></i> MIN <i></i> | | 2c. DATE PRONOUNCED DEAD
Month <i>2</i> Day <i>24</i> Year <i>1969</i> | 2d. HOUR <i>8:30</i> <i>A</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>PENNA</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>SILVER SPRING'S</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HOLY CROSS</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Superintendent</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>4101 Hewitt Ave</i> | |
| 14. FATHER'S NAME First <i>Chas</i> Middle <i>E.</i> Last <i>FRANKENFIELD</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Eva</i> Middle <i>Gertrude</i> Last <i>BURTON</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>214-03-8651</i> | | 17. INFORMANT <i>RUTH J. FRANKENFIELD</i> | | | ADDRESS <i>SEE # 13</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>4123</i>
IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary Artery Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <i>19</i> P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Belden R. Reap</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Febr. 24, 1969</i> | | | |
| EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, City, Town, or County) <i>See # 13</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i> | | 23b. DATE <i>2/25/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> | | 23d. LOCATION (City or Town) <i>SUITLAND P.G. MD.</i> | | (County) (State) | |
| 24. FUNERAL DIRECTOR <i>Joseph Gaulea's SONS - WASHINGTON D.C.</i> | | | | ADDRESS | | 25a. REGD. BY REGISTRAR <i>FEB 26 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

MEDICAL CERTIFICATION

03531

03589

| | | | |
|--------------|--|------------------------------------|--|
| NAME | | MR. CHAS. D. DODGE | |
| AGE | | 34 | |
| SEX | | M | |
| RACE | | W | |
| RELIGION | | M | |
| EDUCATION | | H.S. | |
| OCCUPATION | | Carpenter | |
| RESIDENCE | | 123 Main St., Boston, Mass. | |
| DATE | | 10/15/1909 | |
| BY | | J. H. Smith, M.D. | |
| PLACE | | Boston, Mass. | |
| REMARKS | | Patient is healthy, no complaints. | |
| SIGNATURE | | J. H. Smith | |
| TITLE | | Physician | |
| HOSPITAL | | None | |
| CLINICAL | | None | |
| LABORATORY | | None | |
| X-RAY | | None | |
| PATHOLOGY | | None | |
| PHYSIOLOGY | | None | |
| THERAPEUTICS | | None | |
| DIAGNOSIS | | None | |
| PROGNOSIS | | None | |
| TREATMENT | | None | |
| FOLLOW-UP | | None | |
| DISCHARGE | | None | |
| RE-ENTRY | | None | |
| REMARKS | | Patient is healthy, no complaints. | |
| SIGNATURE | | J. H. Smith | |
| TITLE | | Physician | |
| HOSPITAL | | None | |
| CLINICAL | | None | |
| LABORATORY | | None | |
| X-RAY | | None | |
| PATHOLOGY | | None | |
| PHYSIOLOGY | | None | |
| THERAPEUTICS | | None | |
| DIAGNOSIS | | None | |
| PROGNOSIS | | None | |
| TREATMENT | | None | |
| FOLLOW-UP | | None | |
| DISCHARGE | | None | |
| RE-ENTRY | | None | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02583

Item 9 Film G409 2/25/69

Item 9 Film G410 3/7/69 kk

CERTIFICATE OF DEATH

02578

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>KENSINGTON</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>KENSINGTON</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>9709 ELROD ROAD</u> | | | | d. STREET ADDRESS
<u>9709 ELROD ROAD</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>GEORGE B. FURMAN</u> | | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>17</u> Year <u>1969</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>CAUCASIAN</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-13-1879</u> | |
| 9. AGE (In years, months, and days)
<u>89</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ATTORNEY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>LAW</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>ASHVILLE NORTH CARL.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>UNITED STATES</u> | | | | | | | |
| 13. FATHER'S NAME
<u>ROBERT MCKNIGHT FURMAN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY BACON MATTHEWSON</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>578-46-8352</u> | | 17. INFORMANT
<u>10205 PERTENAND RD. SIL. SP. FRANCIS FURMAN, SON, MD.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRADYCARDIA with CARDIAC ARREST</u>
4409 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio Sclerosis</u>
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>54h</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Emphysema - Chronic Head Tract Infection</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> to <u>Feb 17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>February 15</u> 19 <u>69</u> , and that death occurred at <u>245</u> P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Richard B. Perry</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2-17-69</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>RICHARD B. PERRY M.D.</u> | | | | 22d. ADDRESS
<u>2001-eye St N.W. WASH D.C.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2-20-1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Mausoleum</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Colmar Manor, Prince Georges Co. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</u> | | | | 25a. FILED BY REGISTRAR
<u>FEB 21 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

05330

05330

05330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|---|--|--|---------------------------------|---|-----------------------------------|-------|------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
AM PM | | | |
| 02584 | | | BERTHA Frances GILBERT | | | February 16, 1969 | | | 12:30 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| Female | | White | | December 16, 1894 | | | 74 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Pennsylvania | | America U.S. | | | | Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | | Washington San + Hosp | | | HOUSEWIFE | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER | | | | |
| Maryland | | | | Prince George's W. Hyattsville | | | | 2005 Oglethorpe St. | | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | |
| IRVIN - Francis | | | Mary Shoesmith | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | |
| No | | | | 265-54-9245 | | ALBERT H. GILBERT
PT'S CHART | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Aspiration
351X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bulbar palsy -
DUE TO, OR AS A CONSEQUENCE OF (c) Status post Craniotomy | | | | |
| | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hrs
3 d
3 d | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Trigeminal Neuralgia L. Div I + II | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 2-13-69 | | Trigeminal Neuralgia | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-6-1969, to 2-16-1969, that (I) (we) last saw the deceased alive on 2-15-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Jonathan M. Williams MD | | | | | | 22c. DATE SIGNED
2-16-69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Jonathan M. Williams | | | | | | 22e. ADDRESS
808 Pershing Dr. Silver Spring | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| BURIAL | | 2-19-1969 | | FORT LINCOLN CEM | | COLMAR MANOR, MD | | | | | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS Co. RIVERDALE, MD | | | | | | 25a. REC'D BY REGISTRAR
FEB 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

(Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>02585</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02580</p> </div> </div> | | | | | | | | | | | |
|---|--|------------------------------|---|---|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | | | c. LENGTH OF STAY in 1b
<u>4 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HYATTSVILLE</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Cedar Haven Rest Home</u> | | | | | | d. STREET ADDRESS
<u>7117 Country Club Court</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Laura</u> Middle <u>N.</u> Last <u>Giltner</u> | | | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>5</u> Year <u>1969</u> | | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Mar. 29, 1894</u> | | 9. AGE (In years last birthday)
<u>74</u> yrs. | | IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
IF UNDER 24 HRS. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Sidney Tyler</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Cooper</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO.
<u>518-62-3861</u> | | 17. INFORMANT
<u>Harriet G. Yeatman</u> Address <u>7117 Country Club Ct. Hyattsville, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
<u>4409</u> DUE TO (b) <u>Congestive Heart Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Atherosclerosis</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 wk</u>
<u>Month</u>
<u>Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Diabetes mellitus Senility</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. <u></u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 20, 1967</u> , to <u>Feb 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 31, 1969</u> , and that death occurred at <u></u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Philip E. Jones M.D.</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2-5-69</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Philip E. Jones, M.D.</u> | | | | | | 22d. ADDRESS
<u>500 Pershing Drive Silver Spring Md. 20910</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | | 23b. DATE THEREOF
<u>2/7/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION (City/town or county) (State)
<u>Prince Georges County, Md</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>The S.H. Hines Company</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>FEB 7 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

12584

12584

12584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR P | | |
| Richard Anthony Golden | | | | | | Month Day Year
February 10 1969 | | 3:48M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | White | | 24 February 1922 | | 46 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Pennsylvania | | USA | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | The Clinical Center | | | Merchant Seaman | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Pennsylvania | | | | | Philadelphia | | | | 259 West Johnson Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last
John J. Golden | | | First Middle Last
Mary Miller | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | 073-14-8570 | | The Medical Record Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Left ventricle to left atrium fistula</u> | | | | | | | | | 6 days | |
| DUE TO, OR AS A CONSEQUENCE OF <u>prosthesis</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) <u>Placement of Starr Edwards mitral valve /</u> | | | | | | | | | 6 days | |
| DUE TO, OR AS A CONSEQUENCE OF <u>insufficiency</u> | | | | | | | | | | |
| (c) <u>Rheumatic heart disease causing severe mitral /</u> | | | | | | | | | 30 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| <u>Low cardiac output with renal and hepatic failure</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2/4/69
2/10/69 | | Mitral valve disease | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | City or Town | | County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>30 Dec.</u> , 19 <u>68</u> , to <u>10 Feb.</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>10 February</u> 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | |
| <u>Lynn M. Peterson MD</u> | | | | | | 2/11/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| Lynn M. Peterson, M.D. | | | | | | The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| Burial | | 2-15-69 | | St. Thomas Cemetery | | Archibald, Penna. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | DATE FEB 13 1969 | | <u>Charles Judge</u> | | |



TO: [illegible]
FROM: [illegible]
DATE: [illegible]
AMOUNT: [illegible]
[illegible text follows]

[illegible text block]

[illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02582

02587

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) GRACE L GOODWIN | | | 2a. DATE OF DEATH ^{Actual}
Month FEB Day 15 Year 69 | | | 2b. HOUR
3 P M | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JAN 18, 1898 | | 6. AGE (In years
lost birthday)
72 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign
country) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) 1400 FENWICK LANE | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1400 FENWICK LANE #80B | | |
| 14. FATHER'S NAME First Middle Last
HOWARD WEBB | | | 15. MOTHER'S MAIDEN NAME First Middle Last
MATTIE WILLIAMS | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
578 14 4486 | | 17. INFORMANT
MRS VIRGINIA D. PEEL | | | Address 319 ELM AVE
TAKOMARK, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiency
4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease, cardiac enlargement
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unable to state | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JAN 29, 1968 , to JAN 25, 1969 , that (I) (we) last saw the deceased alive on January 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Aaron H. Traum M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
Feb 15, 1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
AARON H. TRAUM M.D. | | | | | | 22e. ADDRESS
8237 Georgia Ave - Silver Spring, Maryland. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-18-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Wood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Wash D.C. | | | | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS Co. ADDRESS 1400 CHAPIN ST. N.W. WASH. DC | | | | 25a. RECD BY REGISTRAR
FEB 19 1969 DATE | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

03280

UNITED STATES OF AMERICA

03280

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES OF AMERICA" and "DEPARTMENT OF" are faintly visible.]

[Faint text along the right margin, possibly a date stamp or administrative note.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film 410 3/5/69 kkk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
02588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02583

| | | | | | | | | | |
|---|--------------|--|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(Type or Print)
James Edward Grady | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 2 - 20 69 | | | 2b. HOUR
12:07A | | | |
| 3. SEX
Male | 4. RACE
C | 5. DATE OF BIRTH
6-6-53 | 6. AGE (In years last birthday)
16 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month 2 Day 20 Year 1960 | | | 2d. HOUR
12:07A |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San & Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1407 1/2 Merrimac Dr. |
| 14. FATHER'S NAME
First Deceased Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Clara Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT ADDRESS
Clara Grady 1407 1/2 Merrimac Dr. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Exsanguination due to gunshot wound</u>
922-9
DUE TO, OR AS A CONSEQUENCE OF <u>in the left thigh</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR XX 10:30 AM 2-19 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Deceased shot in left thigh accidentally by stepfather | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No.
1407 1/2 Merrimac St. Hyattsville P.G. Md. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Peap | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
Feb. 20, 1969 | |
| EXAMINER'S NAME (Type)
BELDEN R. PEAP, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county)
Stanton, Va. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
2-22-69 | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
Stanton, Va. | | | |
| 24. FUNERAL DIRECTOR
Prozin 389 R.I. on nu. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE FEB 26, 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

03250

1000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" and in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02589

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02584

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|--|---------|------------------|--|--|------|--|------|---|--|--|----------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH MATED | | | Month Day Year | | | 2b. HOUR | | |
| James W Graham | | | | | | Feb 26 1969 | | | 18 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | OAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| m | w | 10-27-1914 | 54 YRS | | | | | Feb 26 | | | 18 M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| Virginia | | | USA | | | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | | Suburban | | | MECHANIC | | | School BOARD | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| md | | | Montgomery | | | Rockville | | | YES | | | 13919 Travilah RD | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| E. E. Graham | | | Meadie Sowers | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| Yes | | | WWII | | | 229-01-6868 | | | Ruby Lee-Graham- wife - same item #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Ruptured Cerebral Aneurysm with. | | | | | | | | | | | | 19 days - | | |
| 4309 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | 6 days | | |
| (b) Cerebral Infarction | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| Hemorrhage - from Rectal Ulcers - | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | |
| 19 Feb 1969 | | | | Repair of Cerebral Aneurysm | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | | |
| 21d. INJURY WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | | | | | |
| John G. Ball | | | | 7936 Old Georgetown Rd. Bethesda, Md. | | | | Feb 26, 1969 | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | |
| Burial | | | | 3/1/69 | | | | Darnestown | | | | | | |
| | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| | | | | | | | | Darnestown, Montg. Maryland | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Tyson Wheeler Funeral Home 1331 Rockville Pike Rockville, Maryland | | | | FEB 28 1969 | | | | Charles Judge | | | | | | |

03250

UNITED STATES DEPARTMENT OF AGRICULTURE

03250

ANNUAL REPORT OF THE

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1911

1911
UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

| | | | | | | | |
|--|-------------------------|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print)
Michael E. Granger | | First MICHAEL Middle ENDICOTT Last GRANGER | | 2a. DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>
Feb. 23 1969 | | 2b. HOUR
8:30 | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
6-16-1960 | 6. AGE (In years last birthday)
8 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month Feb. Day 23 Year 1969 | |
| 7a. BIRTHPLACE (State or foreign)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery. | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4 West Kirk Street | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4 West Kirk Street | |
| 14. FATHER'S NAME First DAVID Middle I Last GRANGER | | 15. MOTHER'S MAIDEN NAME First DEBORAH Middle WILDES Last GRANGER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MR. STEPHEN GRANGER, UNCLE, 3510 ROPMAN | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral severe
485x
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
John G. Ball | | EXAMINER'S NAME (Type)
John G. Ball | | M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
Feb-24, 1969 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
2-25-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Prince Georges Co., Md | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | 25a. REC'D BY REGISTRAR
FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Thomas Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03288

SECTION 10, TOWNSHIP 10N, RANGE 10E, COUNTY OF HANCOCK, STATE OF MINNESOTA

WITNESSES THE HANDS OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF HANCOCK, MINNESOTA, THIS 10TH DAY OF JANUARY, 1913.

03288

10 JAN 1913

THE STATE OF MINNESOTA, COUNTY OF HANCOCK, ss. I, the undersigned, Clerk of the District Court of the County of Hancock, Minnesota, do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears in the records of the District Court of the County of Hancock, Minnesota.

WITNESSED my hand and the seal of the District Court of the County of Hancock, Minnesota, this 10th day of January, 1913.

JOHN J. GILL, Clerk of the District Court of the County of Hancock, Minnesota.

10 JAN 1913



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02591

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02586

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Florence Bell Green | | | 2a. DATE OF DEATH
Month Day Year
February 27 1969 | | | 2b. HOUR
P M
2:55 | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
Sept. 26, 1880 | | 6. AGE (In years last birthday)
88 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Asbury Methodist Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
3404 Old York Road | | 14. FATHER'S NAME
First Middle Last
William Henry Green | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Hannah Mary Fogel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-01-1644-D | | 17. INFORMANT
Address
Asbury Methodist Home, Gaithersburg, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u>
4330 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WKS
5 YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Hypertensive Cardiovascular disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/63</u> , 19 <u>63</u> , to <u>2/27/69</u> , that (I) (we) lost saw the deceased alive on <u>2/25/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Henry E. Scruggs</u> | | | | | | 22c. DATE SIGNED
2/27/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. REC'D BY REGISTRAR
DATE MAR 11 1969 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/1/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
<u>Wm. J. Tubner & Sons Inc.</u> | | | | 25. REGISTRAR'S SIGNATURE
<u>James Judge</u> | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|-----------------|---|--|--|--|--|--|--|---------------------|
| 02592 | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) First Middle Last
RUTH KATHARYN GRIMES | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 2-9 1969 | | 2b. HOUR M | |
| 3. SEX
Fe | 4. RACE
CAUC | 5. DATE OF BIRTH
NOV 6 - 1899 | 6. AGE (In years last birthday) 77 69 | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year 2 - 9 1969 | 2d. HOUR M 10:00 AM |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2421 SHANNONDALE DRIVE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NURSING | | 12b. KIND OF BUSINESS OR INDUSTRY NURSE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montgom | | 13c. CITY OR TOWN Sil. Spr. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2621 Shannondale Dr. | |
| 14. FATHER'S NAME First Middle Last
JOHN GRIMES | | | 15. MOTHER'S MAIDEN NAME First Middle Last
LAURA FISHER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO. 212-32-4607 | | 17. INFORMANT DOROTHEA CRISTOFOLI | | ADDRESS WASHINGTON DC 4201 CATHEDRAL AVENUE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
4/123 DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Keap | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED Feb. 9 1969 | |
| EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE FEB 12 - 1969 | | 23c. NAME OF CEMETERY OR CREMATORY BETHEL | | 23d. LOCATION (City or Town) FREDERICK | | 23e. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR | | ADDRESS UNION | | 25a. REC'D BY REGISTRAR FEB 13 1969 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02593</div> <div> <div>1</div> <div> <div>DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>02588</div> </div> | | | | | | | | | | | |
|--|--|--|---|--|-------------------------------------|---|--|---|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) CAREY WAYNE GRIMSLEY | | | | | | 2a. DATE OF DEATH 2 Month 21 Day 69 Year | | | 2b. HOUR 9 15 P M | | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH 9-8-85 | | | 6. AGE (In years last birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Produce | | | 12b. KIND OF BUSINESS OR INDUSTRY Salesman | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C. | | | 13b. COUNTY -- | | 13c. CITY OR TOWN WASHINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5701 5th St, NW | | |
| 14. FATHER'S NAME First JAMES Middle -- Last GRIMSLEY | | | | 15. MOTHER'S MAIDEN NAME First MILDRED Middle -- Last TAYLOR | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service) -- | | | | 16b. SOCIAL SECURITY NO. 578-26-2085 | | 17. INFORMANT Julia H. Grimsley Address 5701 5th Str. N.W., Wash. DC | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) malignant tumor of the prostate
1420
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-4 , 19 69 , to 2-21 , 19 69 , that (I) (we) last saw the deceased alive on 2-21 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Boris Rabkin DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 2-22-69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) BORIS RABKIN MD. | | | | | | 22e. ADDRESS 315 Scott Drive Silver Spring | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-25-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland Pr. Georges Md. | | | | | |
| 24. FUNERAL DIRECTOR Paul J. Smith ADDRESS Silver Spring, Md. | | | | | | 25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | 25b. REGISTRAR'S SIGNATURE FEB 27 1969 | | | |

03228

DEPARTMENT OF STATE

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02594

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02589

| | | | | | | | | | | | |
|---|-------------------------|---|--|---|--|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print) <i>Betty</i> | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <i>Feb 23</i> | | 2b. HOUR
<i>8:45</i> AM | |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH | | 6. AGE (in years
last birthday)
<i>69</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month <i>Feb</i> Day <i>23</i> Year <i>1969</i> | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Suburban Hosp</i> | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>DC</i> | | 13b. CITY OR TOWN
<i>Washington</i> | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
<i>5406</i> | | | 13e. STREET AND NUMBER
<i>Chase Plaza
Corn. Ave</i> | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma, gastro-esophageal junction with</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Widespread metastases</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE <i>John G. Ball</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
<i>Feb 24, 1969</i> | | | |
| 23a. BURIAL (Cremation,
Removal (Specify)) | | 23b. DATE
<i>2-28-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>U of Md. Med School</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore, Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 3 1969</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

86238

02224

11/11/68

11/11/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
45M - 11-69

| 02595 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02590 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First ALVIN ALVIN Middle W. Last HALL | | | | | | | | | | 2a. DATE OF DEATH FEB Month 11 Day 1969 Year | | | | | | | | | | 2b. HOUR 9230 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX MALE | | | | | | | | | | 4. RACE WHITE | | | | | | | | | | 5. DATE OF BIRTH Aug. 23, 1988 | | | | | | | | | | 6. AGE (In years last birthday) 80 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Pa. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cherry Chase | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda - Sil Spring Ave Home | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Director of Engraving U.S. Govt | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland DC | | | | | | | | | | 13b. CITY OR TOWN Sil. Spring | | | | | | | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 1319 Kalnia Rd., N.W., DC Wash. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Charles Middle W. Last Hall | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Jane Middle Last Marland | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. 579-60-0679 | | | | | | | | | | 17. INFORMANT Alvin W. Hall, Jr. Old West Mountain Road, Ridgefield, Conn. 06877 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4409 Bronchopneumonia | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 2 da | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Genl Arteriosclerosis | | | | | | | | | | 6 m | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 46 to Feb 11, 19 69, that (I) (we) last saw the deceased alive on Feb 8, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Arthur H Lewis MD | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 2-11-69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS | | | | | | | | | | 22e. ADDRESS 1733 N St NW Wash DC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE Feb. 14, 1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) Rockville, (County) Montgomery (State) Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Wm E. Humphrey | | | | | | | | | | ADDRESS 34 Georgia Ave Silver Spring, Md. | | | | | | | | | | 25. REC'D BY REGISTRAR DATE 19 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

7250

279-6077-9500-20-955

:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|------------------------------|--|--|------------------------------------|---|---|--|-----------------------------------|--|-----------------------------|
| 02596 | | | | | 02591 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| First Middle Last
Joseph A. Hamilton | | | | | Month Day Year
Feb 24 1969 | | | | | 4:00 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| male | | white | | 3/7/93 | | | 75 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Deurban Hospital | | | Govt | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | Bethesda | | | | 9106 KITTERY LANE | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| John E. Hamilton | | | Cecilia Miles | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| Yes | | | 1917 | | Sydney Hamilton - Son | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | Feb 2-69 | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) EMPHYSEMA | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) LEFT PNEUMONECTOMY (CARCINOMA) | | | | | | | | | | Dec-30-68 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 12-30-68 | | | CARCINOMA LEFT LUNG | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1968, to Feb 20, 1969, that (I) (we) last saw the deceased alive on Feb 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE James E. Nolan M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Feb 20-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) James E. Nolan | | | | | | 22e. ADDRESS 5401 WESTERN AVE NW WASHINGTON DC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 2-24-1969 | | Arlington National Cemetery | | | Arlington County, Virginia | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | FEB 24 1969 | | J. Gawler's Sons | | | |

02587

02587

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 410 MARYLAND STATE DEPARTMENT OF HEALTH
2-27-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02597

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02592

| | | | | | | | | |
|--|---------------------|---|---|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Melvin Arthur Hardisty | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2 - 9 1969 | | | 2b. HOUR M | | |
| 3. SEX Male | 4. RACE Cauc | 5. DATE OF BIRTH March 2, 1930 | 6. AGE (In years last birthday) 38 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month 2 Day 9 Year 1969 | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Mont. | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hydro Crane operator | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. CITY OR TOWN BELTSVILLE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 4804 Howard Ave. Beltsville | | |
| 14. FATHER'S NAME First Burton Middle Roby Last Hardisty | | | 15. MOTHER'S MAIDEN NAME First Katherine Mae Middle Gates Last Gates | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO. 220246688 | | | 17. INFORMANT MRS JOYCE K. HARDISTY ADDRESS SAME AS # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure, cause
782.4
DUE TO, OR AS A CONSEQUENCE OF undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Feb. 9, 1969 | | |
| EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 2-12-1969 | | 23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON MEM PK | | 23d. LOCATION (City or Town) HYATTSVILLE, MARYLAND | | (County) (State) |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD | | | | 25a. RECEIVED BY REGISTRAR FEB 13 1969 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

0222

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

0222

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 |
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------|-----------|--|--|--|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | | Middle | | | Last | | |
| HARRIETTE | | | ALEXANDER | | | HARMON | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| Female | | White | | June 19 1895 | | 73 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| W. Va. | | | | USA | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| Takoma Park | | | | 12 Cleveland Avenue | | | | Homemaker | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | | Mont. | | | | Tak. Pk. | | 13e. STREET AND NUMBER
12 Cleveland Avenue | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| First Middle Last
Dr. Edgar Alexander | | | | | | First Middle Last
Gertrude Faris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | |
| no | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | |
| DR. Ernest E. Harmon | | | | | | | | | | 9301 Colesville Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Hypertensive Cardiovascular Disease</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| <u>Essential Hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | |
| | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 22a. ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | | | | | 22b. DATE SIGNED <u>Feb. 19, 1969</u> | | | | | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | | | | | ADDRESS <u>254 Carroll Ave</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | |
| <u>Burial</u> | | | | <u>Feb. 24, 1969</u> | | <u>Arlington National Cemetery</u> | | | | <u>Arlington Virginia</u> | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | |
| <u>Takoma Funeral Home Inc</u> | | | | | | <u>J. Arthur Walters</u> | | | <u>FEB 21 1969</u> | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

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02583

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| | | | | | |
|---|---|---|--|--|---|
| 02599 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 02594 | |
| Item 8 Film 410 3/14/69 kk | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Raymond Lawson Harper</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>Feb. 28 1969</i> | | 2b. HOUR
Min
<i>2:45</i> |
| 3. SEX
<i>male</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
<i>5-28-94</i> | | 6. AGE (In years lost birthday)
<i>74</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>Indiana</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> Md | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban Hotel inager</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD.</i> | | 13b. COUNTY
<i>Mont. Co.</i> | 13c. CITY OR TOWN
<i>Silver Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>8510-46 St. - No 715.</i> |
| 14. FATHER'S NAME First Middle Last
<i>Charles J. Harper</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Elizabeth Monahan</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>442-03-1377</i> | 17. INFORMANT
<i>Elizabeth J. Harper</i> Address <i>Daughter.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Multiple Pulmonary emboli</i>
<i>450X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Pulmonary Fibrosis</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/27</i> , 19 <i>69</i> , to <i>THE PRESENT</i> and (I) (we) last saw the deceased alive on <i>2/28</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Edward W. Youngblood</i> (DEGREE) ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Feb 28, 1969</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>E. YOUNG BLOOD</i> | | 22e. ADDRESS
<i>Washington Clinic, Wash. D.C. 20015</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Cremation</i> | | 23b. DATE
<i>March 3, 1969</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Lincoln</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Bladensburg, Md</i> |
| 24. FUNERAL DIRECTOR
<i>Warner E. Humphrey</i> | | ADDRESS
<i>8434 Ga. Ave. Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 4 1969</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

03350 (01)

03350

STATE OF TEXAS

10/10/11

10/10/11

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 02600 | | 02595 | |
| 1. DECEASED-NAME (Type or Print) First Middle Last
William Francis Harper | | | |
| 3. SEX
Male | | 4. RACE
White | |
| 5. DATE OF BIRTH
Sept 2, 1917 | | 6. AGE (In years last birthday)
51 YRS | |
| 7a. BIRTHPLACE (State or foreign country)
Wash. DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
9316 Wire Ave | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life when retired)
Employee PEPCO - Govt Services, Elec. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | |
| 13c. CITY OR TOWN
Silver Spg. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
9316 Wire Avenue | | | |
| 14. FATHER'S NAME First Middle Last
William F. Harper Jr. | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mollie Harrison | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
110-31824 | |
| 17. INFORMANT
Dorothy Harper | | 17. ADDRESS
9316 Wire Ave. Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound in
955X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Head with exsanguination
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
10-2-7 1969 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Deceased shot self in mouth with a 30-30 rifle | | 21d. LOCATION Street or R.F.D. No. City or Town County State
9316 Wire Ave. Sil. Spg. Montg. Md. | |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
9316 Wire Ave. Sil. Spg. Montg. Md. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22b. DATE SIGNED
Feb. 8, 1969 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb 11, 1969 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 25a. REC'D BY REGISTRAR
FEB 13 1969 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

03232

MEDICAL EXAMINATION REPORT OF A MAN

03232

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 |
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02601

02596

Items 5&13 Film 410 3/10/69 kk

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Dorine V. HARRIS</i> | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>18</i> Year <i>69</i> | | | 2b. HOUR
<i>4:55 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>N.</i> | | 5. DATE OF BIRTH
<i>11-7-21 1920</i> | | 6. AGE (In years lost birthday)
<i>48 YRS.</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA.</i> | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 1D. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Holy Cross Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>md.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Kensington</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First <i>Unknown</i> Middle <i></i> Last <i></i> | | 15. MOTHER'S MAIDEN NAME
First <i>Alice</i> Middle <i>Crockett</i> Last <i></i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INEORMANT
<i>Barbara Jackson: 10721 Shaftsbury St. Kensington, Md.</i> | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>pt. middle cerebral a. thrombosis</i>
<i>4330</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Cerebral arteriosclerosis +</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>hypertension</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>years</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Diabetes mellitus; old anterior myocardial infarct</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-15, 1969</i> to <i>2-17, 1969</i> , that (I) (we) last saw the deceased alive on <i>2-17, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>John J. W. [Signature]</i> | | 22c. DATE SIGNED
<i>2-18-69</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Taron Berger, M.D.</i> | | | |
| 22e. ADDRESS
<i>SILVER SPRING, MD 20910</i> | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Buried</i> | | 23b. DATE
<i>2-24-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington National.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Arlington, Va.</i> | |
| 24. FUNERAL DIRECTOR
<i>Berge R. Browder Rockville</i> | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 26 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03330

03330

THE UNIVERSITY OF CHICAGO

1933-1934

1933-1934

03330

Robert R. Rabinowitz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

02602

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02597

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) David Hauptschein | | | 2a. DATE OF DEATH
Month 2 Day 18 Year 69 | | | 2b. HOUR
11 a M | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
4-16-95 | | 6. AGE (In years last birthday)
73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Austria-H. Y. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Jan. & Hosp. REVIEWAL & ACUTE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
REVIEWAL & ACUTE | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md COUNTY Montgomery | | 13b. CITY OR TOWN
Takoma Park | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7520 Maple Ave. #216 | |
| 14. FATHER'S NAME First Elias Middle Hauptschein Last Hauptschein | | | 15. MOTHER'S MAIDEN NAME First Leah Middle Oreowich Last Oreowich | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war and dates of service)
WW I | | 16b. SOCIAL SECURITY NO.
577-60-2047 | | 17. INFORMANT
Hospital Record | | Address
Takoma Pk. 1600 Carroll Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
5900
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic pyelonephritis, hydronephrosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mon.
10 yr. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of Bladder | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 27 , 19 67 , to Feb. 18 , 19 69 , that (I) (we) last saw the deceased alive on Feb. 18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Arthur S. Busen, M.D. | | | | DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-18-69 | |
| 22d. PHYSICIAN'S NAME (Type)
ARTHUR S. BUSEN | | | | 22e. ADDRESS
10881-LOCKWOOD DR. SS KGA | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
2/19/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
GEO. WASH. CEM. | | 23d. LOCATION (City or Town) (County) (State)
HYATISVILLE, MD. | |
| 24. FUNERAL DIRECTOR
Gealeeg Keene | | | | ADDRESS
42179 | | 25a. REC'D BY REGISTRAR
FEB 24 1969 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Gealeeg Keene | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|---|---|-------------------|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| 02603 | | | | | CERTIFICATE OF DEATH | | | | | 02598 | | | |
| 1. DECEASED-NAME
(Type or print) ROY | | | First ROY | | Middle HAINES HEALD | | Last | | 2a. DATE OF DEATH
2 Month 17 Day 69 Year | | 2b. HOUR
0350M | | |
| 3. SEX
MALE | | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
1-14-94 | | | 6. AGE (In years last birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
NEBRASKA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CARRIAGE HILL E.C.F. BUREAU OF STDS. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
US GOVT. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DC CITY DC | | | 13b. COUNTY DC | | 13c. CITY OR TOWN
WASHINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6201 UTAH AVE N.W. | | | | |
| 14. FATHER'S NAME First Elza W. Middle Heald Last | | | | | 15. MOTHER'S MAIDEN NAME First Lenna Middle Haines Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
J. Heston Heald-7033 Benjamin St. McLean, Va 22101 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL
185X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CARCINOMA, PROSTATE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS
3 MONTHS. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
ARTHRITIS, RHEUMATOID | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N.A. | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N.A. | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTINUING CAUSE OF DEATH
(If either, notify medical examiner)
N.A. | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. N.A. 19 69 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
N.A. | | | | | | | |
| 21d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>
N.A. | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
N.A. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
N.A. | | | | | | | |
| 22a. I certify that (U) (this hospital) attended the deceased from FEB 14, 1969 , to FEB 17, 1969 , that (U) (we) last saw the deceased alive on FEB 16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Donald B. Doty M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
FEB, 17, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) DONALD B. DOTY | | | | | 22e. ADDRESS
1909 HANOVER ST. SILVER SPRING | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
2/19/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR
THE S.H. HINES CO. ADDRESS
2901-14TH ST. N.W. WASHINGTON, D.C. | | | | | 25. REC'D BY REGISTRAR
FEB 19 1969 DATE | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

03582

UNITED STATES

03582

UNITED STATES

UNITED STATES

UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
30M REV. 1/68

| 02604 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02599 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|--|
| Items 1 & 16 Film 409 2/21/69 KK | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
Emma | | | | | Middle
Christina | | | | | Last
Hagg Hagg | | | | | 2a. DATE OF DEATH
Month 10 Day 1969 Year | | | | | 2b. HOUR
8:30 P M | | | | |
| 3. SEX
Female | | | | | 4. RACE
Caucasian | | | | | 5. DATE OF BIRTH
3-28-1882 | | | | | 6. AGE (In years
last birthday)
86 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Sweden | | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Carroll Hall Sanitarium | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
At home - housewife | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
District of Columbia | | | | | 13c. CITY OR TOWN
Washington | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
5406 41st St. N.W. | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Andrew | | | | | Middle
Olson | | | | | Last
Christina | | | | | 15. MOTHER'S MAIDEN NAME
First
Christina | | | | | Middle
Clausen | | | | | Last
Clausen | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO.
666-30-6057 | | | | | 17. INFORMANT
Mrs. George Hamilton, 5406 41st St. N.W., D.C. | | | | | | | | | | Address
(Daughter) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) <u>Arteriosclerosis, generalised, severe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension, chronic</u> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 min
5 yrs +
5 yrs + | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Hemiplegia, left T. Oct 15 1966</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 1966, to <u>Feb 10</u> , 1969, that (I) <u>(see)</u> lost
saw the deceased alive on <u>Feb 10</u> , 1969, and that in (my) <u>(see)</u> opinion death occurred on the date and hour and from the
causes stated above, (I) <u>(see)</u> (did) <u>(see)</u> view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Stewart Clapp MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED
<u>Feb 10 1969</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>Stewart Clapp MD</u> | | | | | | | | | | | | | | | 22e. ADDRESS
<u>5415 W. Cedar Lane Bethesda Md</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | | 23b. DATE
2-12-1969 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Memorial Park | | | | | 23d. LOCATION (City or Town) (County) (State)
Evanston, Illinois | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5150 Wisc. Ave.
N.W., Wash., D.C., 20016 | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>W. Charles Judge</u> | | | | | | | | | |

notified.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 118

| 02605 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 02600 | |
|--|--|--|--|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
PAUL J. HEISTER | | | | | 2a. DATE OF DEATH Month Day Year
FEB 15 1969 | | 2b. HOUR
6:59 M |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
5/25/01 | | 6. AGE (In years lost birthday)
67 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
PENNA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
406 1ST STREET | | 14. FATHER'S NAME First Middle Last
Samuel Heister | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lesta Johns | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
Yes | | 16b. SOCIAL SECURITY NO.
176-09-8115 | | 17. INFORMANT
ROBERT R HEISTER - SON. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma, Liver</u>
1978
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>1-27, 1969</u> , to <u>2-15</u> , 1969, that (H) (we) last saw the deceased alive on <u>2-15</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J Thornton Boswell M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
2-15-69 | |
| 22d. PHYSICIAN'S NAME (Type)
J Thornton Boswell M.D. | | | | 22e. ADDRESS
8600 Old Georgetown Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-18-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Darnestown Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Darnestown Mont. Md | |
| 24. FUNERAL DIRECTOR
Robert A Pumfrey | | | | 25a. REC'D BY REGISTRAR
4557 ADDRESS
Bethesda, Md | | 25b. REGISTRAR'S SIGNATURE
FEB 19 1969 | |

10-230

EXHIBIT TO DEED

23382

[Faint, mostly illegible text, likely a deed or legal document. Some words like "whereas" and "and" are visible.]

WITNESSETH THAT

1. Thomas Howell

[Faint text at the bottom of the page, possibly a signature or additional legal notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| 02606 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02601 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|------------------------|--|--|--|--|--|--|--|------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR P | | | | | | | | | |
| First Middle Last
Vanessa Kay Helm | | | | | | | | | | Month Day Year
Feb. 4 1969 | | | | | | | | | | 10:40M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Female | | | White | | | Feb. 4, 1969 | | | YRS. | | | MONTHS DAYS | | | HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Montgomery | | | | | | Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Olney | | | Montgomery General Hospital | | | none | | | | | | none | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Maryland | | | Montgomery | | | Gaithersburg | | | | | | 22 S. Frederick Avenue | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | |
| William A. Helm | | | Betty Mae Riffle | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | |
| no | | | none | | | Records Montgomery General Hospital, Olney, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7769 Congenital atelectasis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Spontaneous (4 hr 903) | | | | | | | | | | 11 hr | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | 11 hr | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 22a. I certify that (I) (this hospital) attended the deceased from 2/4, 1969, to 2/5, 1969, that (I) (we) last saw the deceased alive on 2/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. NAME OF CEMETERY OR CREMATORY | | | | | 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| Charles H. Ligon, M.D. | | | | | Cross Roads | | | | | Sandy Spring, Maryland | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Removal | | | | | Feb. 15 1969 | | | | | Cross Roads | | | | | Warmack Maddison Missouri | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Francis H. Barber | | | | | Laytonville Md. | | | | | FEB 11 1969 | | | | | Judge | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

1. James Earl Ray
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 96. James Earl Ray
 97. James Earl Ray
 98. James Earl Ray
 99. James Earl Ray
 100. James Earl Ray

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>02607</div> <div> <div>02602</div> <div> <div>02602</div> <div>02602</div> </div> </div> | | | | | | | | | | | |
|---|--|-------------------------------------|--|--|--|--|--|--|--|---|--|
| <div>1. DECEASED-NAME</div> <div>(Type or Print)</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>KENNETH</div> <div>W.</div> <div>HENDERSON</div> | | | | | | <div>2a. DATE KNOWN</div> <div>OF</div> <div>DEATH</div> <div>ESTI-</div> <div>MATED</div> <div>Month</div> <div>Day</div> <div>Year</div> <div>2</div> <div>25</div> <div>1969</div> <div>8:35 PM</div> | | | | | |
| <div>3. SEX</div> <div>MALE</div> | | <div>4. RACE</div> <div>WHITE</div> | | <div>5. DATE OF BIRTH</div> <div>8/3/19</div> | | <div>6. AGE (In years last birthday)</div> <div>49</div> <div>YRS.</div> | | <div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div> | | <div>IF UNDER 24 HRS</div> <div>HOURS</div> <div>MIN.</div> | |
| <div>7a. BIRTHPLACE (State or foreign country)</div> <div>Washington, D.C.</div> | | | <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U. S. A.</div> | | | <div>8. MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div> | | | <div>9. COUNTY OF DEATH</div> <div>MONTGOMERY</div> | | |
| <div>10. CITY OR TOWN OF DEATH</div> <div>SILVER SPRING</div> | | | <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>HOLY CROSS HOSP.</div> | | | <div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>excavating</div> | | | <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Stokes</div> | | |
| <div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>MD.</div> | | | <div>13b. COUNTY</div> <div>MONTGOMERY</div> | | | <div>13c. CITY OR TOWN</div> <div>ROCKVILLE</div> | | | <div>13d. INSIDE CITY LIMITS?</div> <div>YES</div> <div>NO</div> | | |
| <div>14. FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>CASSIUS</div> <div>HENDERSON</div> | | | <div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>EDNA</div> <div>PEARL</div> <div>WILEY</div> | | | <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>YES</div> | | | <div>16b. SOCIAL SECURITY NO.</div> <div>577-16-6446</div> | | |
| <div>17. INFORMANT</div> <div>James R. Henderson</div> | | | | | | <div>ADDRESS</div> <div>1034 Towlston Rd.</div> <div>McLean, Va.</div> | | | | | |
| <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Liver failure</div> <div>4560</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(b) Acute hepatic necrosis (steatonecrosis)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c) Gastrointestinal bleeding from esophageal varices.</div> <div>4 days</div> | | | | | | | | | | | |
| <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>Terminal pulmonary edema and aspiration pneumonia.</div> | | | | | | | | | | | |
| <div>19a. DATE OF OPERATION</div> | | | | <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> | | | | <div>20. AUTOPSY?</div> <div>YES</div> <div>NO</div> | | | |
| <div>21a. EXTERNAL CAUSE WAS PRIMARY</div> <div>OR CONTRIBUTING</div> <div>CAUSE OF DEATH</div> | | | | <div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M.</div> <div>P.M.</div> <div>19</div> | | | | <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> | | | |
| <div>21d. INJURY OCCURRED WHILE AT WORK</div> <div>NOT WHILE AT WORK</div> | | | | <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> | | | | <div>21f. LOCATION Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div> | | | |
| <div>22a. I certify that I took charge of the remains described above, held an Autopsy</div> <div>Inspection</div> <div>Inquiry</div> <div>and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div> | | | | | | | | | | | |
| <div>ACTUAL SIGNATURE</div> <div>Belden Reap</div> | | | | | | <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> | | | | | |
| <div>EXAMINER'S NAME (Type)</div> <div>Belden Reap, M.D.</div> | | | | | | <div>DATE SIGNED</div> <div>Feb. 26, 1969</div> | | | | | |
| <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> | | | | <div>23b. DATE</div> <div>March 1, 1969</div> | | | | <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Andrew Chapel</div> | | | |
| <div>24. FUNERAL DIRECTOR</div> <div>Money & King,</div> <div>171 W. Maple Ave.</div> <div>Vienna, Va. 22180</div> | | | | <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>MAR 3 1969</div> | | | | <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Vada</div> | | | |
| <div>23d. LOCATION (City or Town)</div> <div>Fairfax Co., Virginia</div> | | | | | | | | | | | |

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|------------|--|--|--|--|--|--|--|--|--|---------------------------|--|---------------------------|--|------------------------------|--|
| NAME | | WHITE | | SEX | | MALE | | AGE | | 28 | | DATE | | 10-1-33 | |
| BIRTH | | 10-1-05 | | PLACE | | NEW YORK | | CITY | | NEW YORK | | STATE | | NEW YORK | |
| OCCUPATION | | STREET | | 100 | | CITY | | NEW YORK | | STATE | | NEW YORK | | ZIP | |
| EDUCATION | | HIGH SCHOOL | | GRADUATE | | YES | | NO | | YES | | NO | | YES | |
| MARRIAGE | | MARRIED | | SINGLE | | YES | | NO | | YES | | NO | | YES | |
| RELIGION | | CATHOLIC | | PROTESTANT | | YES | | NO | | YES | | NO | | YES | |
| POLITICAL | | DEMOCRAT | | REPUBLICAN | | YES | | NO | | YES | | NO | | YES | |
| MILITARY | | ARMY | | NAVY | | YES | | NO | | YES | | NO | | YES | |
| SMOKING | | SMOKES | | DOES NOT SMOKE | | YES | | NO | | YES | | NO | | YES | |
| ALCOHOL | | DRINKS | | DOES NOT DRINK | | YES | | NO | | YES | | NO | | YES | |
| HISTORY | | ACUTE MYOCARDIAL INFARCTION (MAY 1932) | | CHRONIC MYOCARDIAL INFARCTION (MAY 1932) | | YES | | NO | | YES | | NO | | YES | |
| SYMPTOMS | | PAIN IN CHEST | | SHORTNESS OF BREATH | | YES | | NO | | YES | | NO | | YES | |
| DIAGNOSIS | | ACUTE MYOCARDIAL INFARCTION | | CHRONIC MYOCARDIAL INFARCTION | | YES | | NO | | YES | | NO | | YES | |
| TREATMENT | | REST | | MEDICATION | | YES | | NO | | YES | | NO | | YES | |
| PROGNOSIS | | FAVORABLE | | UNFAVORABLE | | YES | | NO | | YES | | NO | | YES | |
| FOLLOW-UP | | FOLLOW-UP | | NO FOLLOW-UP | | YES | | NO | | YES | | NO | | YES | |
| REMARKS | | PATIENT ADMITTED TO HOSPITAL ON MAY 1, 1932. DIED ON MAY 10, 1932. | | AUTOPSY PERFORMED ON MAY 11, 1932. | | FINDINGS: ACUTE MYOCARDIAL INFARCTION. | | CAUSE OF DEATH: ACUTE MYOCARDIAL INFARCTION. | | MANNER OF DEATH: NATURAL. | | PLACE OF DEATH: HOSPITAL. | | DATE OF DEATH: MAY 10, 1932. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or Print) <i>Archie</i> First <i>B.</i> Middle <i>Highsmith</i> Last | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>20</i> Year <i>1969</i> | | | | 2b. HOUR <i>8:45</i> P.M. | | | | | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>12-15-25</i> | | 6. AGE (In years last birthday) <i>43</i> YRS. | | 7c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>20</i> Year <i>1969</i> | | 2d. HOUR <i>8:45</i> P.M. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Rockville & Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Military Intel.</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>D.I.A.</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>1920 Lewis Ave</i> | | | | | |
| 14. FATHER'S NAME First <i>Beet</i> Middle <i>Highsmith</i> Last <i>Short</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Myrtle</i> Middle <i>Short</i> Last <i>Short</i> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>WW II</i> | | | | 16b. SOCIAL SECURITY NO. <i>578-22-2101</i> | | 17. INFORMANT <i>Myllis Highsmith</i> ADDRESS <i>1920 Lewis Ave.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Aneurysm, congenital, ruptured right mid-cerebral artery</i>
DUE TO, OR AS A CONSEQUENCE OF <i>artery</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4309</i>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED <i>Feb 21, 1969</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 23b. DATE <i>2/25/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>Arlington Va.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Rockville, Md</i> | | | | | | 25a. REC'D BY REGISTRAR <i>FEB 26 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | |

05802

NEWARK, NEW JERSEY

05802

STATE OF NEW JERSEY
DEATH CERTIFICATE

1019-3101

John D. Hall

Attestation

Attestation

Attestation

Attestation

Attestation

Attestation

Attestation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11659

| 02609 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 02604 | |
|---|------------------------------|--|--|--|---------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | |
| EDITH | | | | | HILGEMAN | Month FEB | Day 15 Year 1969 |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 2b. HOUR |
| FEMALE | WHITE | | 11-7-83 | | 85 YRS | | 8:45-8:57 M |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | USA | | | | MONTGOMERY | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | SUBURBAN | | Secretary | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| MARYLAND | | MONTGOMERY | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 4309 BRADLEY LANE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | |
| First Middle Last John F. Hilgeman | | | First Middle Last Kate Klinedinst | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| no | | none | | Family records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Bilateral bronchopneumonia. | | | | | | | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident Right side | | | | | | | 1 month |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis. | | | | | | | years. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | FEB | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 11, 1969, to FEB 14, 1969, that (I) (we) last saw the deceased alive on FEB 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John G. Lofft MD | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED FEB 15/69 | |
| 22d. PHYSICIAN'S NAME (Type) JOHN G. LOFFT | | | | 22e. ADDRESS 2029 QUE ST. N.W. WASHINGTON D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 2/17/69 | | Druid Ridge Cemetery | | Pikesville Md. | |
| 24. FUNERAL DIRECTOR John Burns Sons | | | | ADDRESS Towson, Maryland | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | 25a. REC'D BY REGISTRAR | | DATE FEB 20 1969 | |

10880

00880

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02610 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 02605 | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <u>Thomas J. Himelright</u> | | | | 2a. DATE OF DEATH <u>2</u> Month <u>5</u> Day <u>69</u> Year | | 2b. HOUR <u>1pm</u> | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>6/23/96</u> | | 6. AGE (In years last birthday) <u>72</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <u>VA.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>MONTGOMERY</u> Md. | |
| 10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u> | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Wheaton</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <u>Thomas</u> Middle <u>Luther</u> Last <u>Himelright</u> | | 15. MOTHER'S MAIDEN NAME First <u>Annie</u> Middle <u>Tabler</u> Last <u></u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <u>235-50-4121</u> | |
| 17. INFORMANT <u>Pearl Himelright</u> | | Address <u>Martinsburg</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u>
<u>4123</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary emphysema</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASHD and RHD with aortic stenosis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Cerebral arteriosclerosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-13</u> , 19 <u>59</u> , to <u>2-5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Jason Geiger, M.D.</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>2-5-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u> | | | | 22e. ADDRESS <u>806 PERSHING DRIVE SILVER SPRING, MD. 20910</u> | | | |
| 23a. BURIAL, CREMATION, or other disposition <u>Burial</u> | | 23b. DATE <u>Feb 8, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Frederick County, Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>Howard K. Brown</u> ADDRESS <u>MARTINSBURG, WVA</u> | | | | 25a. REC'D BY REGISTRAR <u>FEB 10 1969</u> DATE | | 25b. REGISTRAR'S SIGNATURE <u>William G. Gage</u> | |

03883

03883

100-10000

100-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
45M 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Anita</i> | | | First <i>B.</i> | | Middle <i>Hines</i> | | Last | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>15</i> Year <i>69</i> | | 2b. HOUR
<i>8:45</i> AM | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>1/18/187</i> | | | 6. AGE (In years last birthday)
<i>82</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS
HOURS <i></i> MIN <i></i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Russia</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Potomac Valley Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>at Home</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>16 Clemson Ct.</i> | | | | |
| 14. FATHER'S NAME First <i>Valadimee</i> Middle <i>Beloff</i> Last <i></i> | | | 15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i></i> Last <i></i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <i>no</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i></i> | | 17. INFORMANT
<i>Mary J Castle</i> Address <i>Rockville Md 16 Clemson Ct</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of the pancreas</i>
<i>157.9</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 mos</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>Chronic brain syndrome 2° to cerebral arteriosclerosis</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>11/16/68</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Abs. exploration</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR <i></i> A.M. <i></i> P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | | | |
| 22a. I certify that, (1) (this hospital) attended the deceased from <i>19</i> , to <i>19</i> , that (1) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>George S. Kenton, M.D.</i> DEGREE <i></i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
<i>2/15/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>GEORGE S. KENTON</i> | | | | | | | | | | 22e. ADDRESS
<i>10620 GEORGIA AVE, S.S. Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | 23b. DATE
<i>2-18-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Reformed Church Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Swiftwater Pa.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Robert A Pomphrey</i> | | | ADDRESS
<i>7557 Wisconsin Ave Bethesda Md.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>Feb 17 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

03200

03200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--|--|---|--|-------------------------|---|--|
| 02612 | | | | | | | | | |
| 02607 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) John Arthur Hinzman | | | | | 2a. DATE OF DEATH February 17 1969 | | 2b. HOUR 7:10 AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 7 October 1961 | | 6. AGE (In years birthday) 7 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) West Virginia | | 13b. COUNTY South | | 13c. CITY OR TOWN Charleston | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Route 7, Box 132 B | |
| 14. FATHER'S NAME First Carl Middle H. Last Hinzman | | | 15. MOTHER'S MAIDEN NAME First Minerva Middle Adkins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, never (unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkin's Disease with Hepatic Failure
201X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hemolytic Anemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 13 Feb. , 19 69 , to 17 Feb. , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 February , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Michael B Mosher, MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 17 February 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) Michael B. Mosher, M. D. | | | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 2-20-69 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) CHARLESTON WEST VA. | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co 1400 Chapin St NW ADDRESS Washington, D.C. | | | | 25a. REC'D BY REGISTRAR DATE FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |

MEDICAL CERTIFICATION

2

26

85

3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|---|--|-----------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Florence none Hordes | | | | | | 2a. DATE OF DEATH Feb Month 23 Day Year 1969 | | | 2b. HOUR 9:30 a.m. | | |
| 3. SEX F | | 4. RACE white | | 5. DATE OF BIRTH 5/15/1886 | | | 6. AGE (In years last birthday) 82 YRS. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Lithuania | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY SELF | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash. D.C. | | | | 13b. CITY OR TOWN Wash. D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2101 16th St. N.W. | | | |
| 14. FATHER'S NAME First Abraham Middle Weinstein Last Reva | | | | 15. MOTHER'S MAIDEN NAME First Reva Middle UNK. Last UNK. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 147-42-6240 | | 17. INFORMANT SANFORD HORDS | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.U.D.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/9 , 19 69 , to 2/23 , 19 69 , that (I) (we) lost the deceased alive on 2/22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Allen Cohen MD. DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/23/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) Allen Cohen MD. | | | | | | 22e. ADDRESS 13515 Georgia Ave, Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb .26, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery | | 23d. LOCATION (City or Town) (County) (State) Lodi, New Jersey | | | | | |
| 24. FUNERAL DIRECTOR Goldberg Fun'l Home 4217 9th. St. Wash. DC | | | | | | 25a. REGD BY REGISTRAR FEB 27 1969 DATE | | 25b. REGISTRAR'S SIGNATURE William J. Judge | | | |

1753

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02615

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02610

| | | | | | | | | |
|---|-------------------|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Caroline E Horvath | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Feb Day 22 Year 1969 | | | 2b. HOUR 11:30 AM <input type="checkbox"/> PM <input type="checkbox"/> | | |
| 3. SEX Fe | 4. RACE W. | 5. DATE OF BIRTH April 14, 1893 | 6. AGE (in years last birthday) 75 YRS. | IF UNDER 1 YEAR
MONTHS 10 DAYS 8 | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
Month Feb Day 22 Year 1969 | | |
| 7a. BIRTHPLACE (State or foreign country) Austria | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH Cherry Chase | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Silver Spring Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5524 Devon Road |
| 14. FATHER'S NAME UNKNOWN | | | 15. MOTHER'S MAIDEN NAME UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, as unknown) No | | | 16b. SOCIAL SECURITY NO. 119-36-447 | | 17. INFORMANT MR EDWARD J. BLOCH ADDRESS 5524-DEVON RD, BETHESDA, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Arterio Sclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 1/2 Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Feb. 22, 1969 | | |
| EXAMINER'S NAME (Type) John G. Ball | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | |
| 23a. BURIAL OR CREMATION REMOVAL (Specify) XXXX | | 23b. DATE 2-25-69 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION (City or Town) Silver Spring (County) (State) Maryland | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS 7557-Wisconsin Ave., Bethesda, Md. | | | | | 25a. REC'D BY REGISTRAR FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

01350

RECEIVED - 10/10/50

RECEIVED - 10/10/50

01350

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-5-64
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02616

02611

| | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) ROBERT Irving HOSKINSON | | | 2a. DATE OF DEATH
Month February Day 12 Year 1969 | | | 2b. HOUR
9:A. M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
January 30, 1890 | | | 6. AGE (In years last birthday) 79 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
12005 Remington Drive | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
12005 Remington Drive | |
| 14. FATHER'S NAME First Middle Last
Holland Hoskinson | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Laura M. --- | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
578-05-7625A | | 17. INFORMANT Address
Julian H. Hoskinson - son - same item 12 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from October , 19 65 , to Feb. 12 , 19 69 , that (I) (we) last saw the deceased alive on Feb 11 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Raymond Bradshaw</i> | | | | | | 22c. DATE SIGNED
Feb 12, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Raymond Bradshaw | | | | | | 22e. ADDRESS
345 University Blvd. W. Silver Spring | | | | |
| 23a. BURIAL, CREMATION, ETC. (Specify)
Buried | | 23b. DATE
2/14/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home 1331 Rock. Pike | | | | ADDRESS
Rockville, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 13 1969 | | 25b. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

32818

CERTIFICATE OF DEATH

32818

ROBERT LIVING
January 30, 1890
White
Virginia, U.S.A.
Silver Spring, 12005
Silver Spring, 12005
Holland Road, near
57-02-5555
Congestive Heart Failure
arteriosclerotic cardiovascular disease
October 1969
p. 12, 1969
Silver Spring
Hockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 02612 | | | | | | | | | | 02612 | | | | | | | | | | | | | | |
|--|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------|--|--|---|--|--|--|--|----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | |
| MARIE | | | | | ARANTO HOWELL | | | | | Month Day Year | | | | | 2 2 1969 | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | | | | |
| Female | | | White | | | 5/20/93 | | | 75 | | | MONTHS DAYS | | | HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | |
| South Carolina | | | USA | | | | | | Montgomery | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Bethesda | | | | | Suburban Hospital | | | | | Housewife | | | | | Housewife | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | | | Montgomery | | | | | Cherry Chase | | | | | YES | | | | | 3528 HANLET PLACE | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | |
| William Morgan Arant | | | | | Cary | | | | | | | | | | | | | | | Bouzares | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | |
| No | | | | | 527-54-2552 | | | | | CECIL L. HOWELL | | | | | Lushington, Md. same | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Massive Intracerebral Hemorrhage | | | | | | | | | | | | | | | 1 month | | | | | | | | | |
| 4309 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Rupture of Aneurysm of left Anterior Cerebral Artery | | | | | | | | | | | | | | | 1 month | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 31, 1968, to February 2, 1969, that (I) (we) last saw the deceased alive on February 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | |
| Robert B. Havell MD | | | | | | | | | | | | | | | | | | | | February 2, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| Robert B. Havell, MD | | | | | | | | | | 5516 Nebraska Ave - Wash. DC | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| CREMATION | | | | | 2/3/1969 | | | | | CEDAR HILL CEMETERY | | | | | SUITLAND, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| HYSONG'S FUNERAL HOME | | | | | | | | | | 1300 N. ST. N.E. | | | | | DATE FEB 5 1969 | | | | | Charles Judge | | | | |

MEDICAL CERTIFICATION

STAFF

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



| <div style="display: flex; justify-content: space-between;"> 02618 MARYLAND STATE DEPARTMENT OF HEALTH 02613 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|--|--|--|---|---|---|---|--|
| 1. DECEASED-NAME (Type or print) John First W Middle Howes Last | | | | | 2a. DATE OF DEATH
Month Feb Day 7 Year 1969 | | | 2b. HOUR 11:30 M | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 5/20/85 | | 6. AGE (In years last birthday) 83 YRS. | | IF UNDER 1 YEAR
MONTHS 8 DAYS 11 | |
| 7a. BIRTHPLACE (State or foreign country) New York | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Accountant | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | 13b. COUNTY Mont | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 611 Oste Blvd. | |
| 14. FATHER'S NAME First John Middle Howes Last | | | | 15. MOTHER'S MAIDEN NAME First Ellen Middle Fletcher Last Sherman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT Son - Harrison S Howes | | Address Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Arterial Accident
4379 DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Coronal & Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) - | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. - City or Town - County - State - | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 , 19 66 , to February , 19 69 , that (I) (we) last saw the deceased alive on 6 February , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Frederick S. Cameron DEGREE - ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED 2/7/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) FREDERICK S CAMERON | | | | | 22e. ADDRESS Rockville Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-10-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) Colmar Manor (County) Prince Georges (State) Maryland | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 3150 Wisc. Ave. N.W., Wash., D.C., 20016 ADDRESS | | | | | 25a. REC'D BY REGISTRAR FEB 13 1969 DATE | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

05017

OFFICE OF DEAN

05017

On 10/10/68, the Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

1. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

2. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

3. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

4. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

5. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

6. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

7. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

8. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

9. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

10. The Dean of the Faculty of the University of California, San Diego, advised that the following information was received from the Dean of the Faculty of the University of California, San Diego, on 10/10/68:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | |
|---|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) WILLIAM HENRY HUTTON | | 2a. DATE OF DEATH 2-6-69 Month Day Year | | 2b. HOUR 3 PM M | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 11-25-1892 | 6. AGE (In years last birthday) 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH KENSINGTON, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GARDENS SAN. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ACCOUNTANT-- | 12b. KIND OF BUSINESS OR INDUSTRY B&OBB | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. COUNTY BALTIMORE | 13b. CITY OR TOWN BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET AND NUMBER 3212 Kenyon Avenue | | |
| 14. FATHER'S NAME First Middle Last William Edward Hutton | | 15. MOTHER'S MAIDEN NAME First Middle Last Lillie Eckhardt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16b. SOCIAL SECURITY NO. 1918-00000-705-05-3097 | | 17. INFORMANT Address REV GERALD A OKERMAN (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Art. scler. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
3 days
2 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 27 , 19 69 , to Feb 5 , 19 69 , that (I) (we) last saw the deceased alive on Feb 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Marvin Wadler MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Feb 5, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) MARVIN WADLER M.D. | | 22e. ADDRESS 8218 Wisc. Av. Beth. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/10/69. | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | | 25a. REC'D BY REGISTRAR FEB 7 1969 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

05012

05012

MINISTRY OF DEFENSE

SECRET
1. The purpose of this document is to provide information on the current status of the defense forces and the results of the latest military exercises.

2. The defense forces are currently in a state of high readiness and are capable of responding to any potential threats. The results of the latest military exercises have been highly satisfactory and demonstrate the effectiveness of the defense forces.

3. The defense forces are currently in a state of high readiness and are capable of responding to any potential threats. The results of the latest military exercises have been highly satisfactory and demonstrate the effectiveness of the defense forces.

4. The defense forces are currently in a state of high readiness and are capable of responding to any potential threats. The results of the latest military exercises have been highly satisfactory and demonstrate the effectiveness of the defense forces.

5. The defense forces are currently in a state of high readiness and are capable of responding to any potential threats. The results of the latest military exercises have been highly satisfactory and demonstrate the effectiveness of the defense forces.

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7. The defense forces are currently in a state of high readiness and are capable of responding to any potential threats. The results of the latest military exercises have been highly satisfactory and demonstrate the effectiveness of the defense forces.

02620

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) <u>John Martin Isaacson</u> | | | 2a. DATE OF DEATH
2 Month 25 Day 69 Year | | | 2b. HOUR
4:08 AM | | | | | |
| 3. SEX
M | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
5-23-1890 | | 6. AGE (In years last birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Minn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Univ. Nurs. Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Cabinet Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Prince Geo. | | | 13c. CITY OR TOWN
Langley Pk. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1603 Merrimac Dr. | |
| 14. FATHER'S NAME First Middle Last
ISAAC ABRAHAMSON | | | 15. MOTHER'S MAIDEN NAME First Middle Last
HENDRIKA JOHNSON | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO.
501-03-4065 | | | 17. INFORMANT (SON) 8117 NEW RIGGS RD
LEE H ISAACSON HYATTSVILLE MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u>
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Diabetes Mellitus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May, 1968</u> , to <u>Feb 25, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Feb 25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Boris Rabkin</u> | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-25-69 | |
| 22d. PHYSICIAN'S NAME (Type)
BORIS RABKIN | | | | | | 22e. ADDRESS
1019 Univ Blvd WHEATON MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
2-1-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
FT LINCOLN CEM | | | 23d. LOCATION (City or Town) (County) (State)
BLADENSBURG MD | | |
| 24. FUNERAL DIRECTOR
W.W. Chambers 8655 Sa Ave Silver Spring Md | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 3 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Producing and
other work

x

10-20-41
x
10-20-41

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 02621 | | MARYLAND STATE DEPARTMENT OF HEALTH | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 02616 | | | | | |
| Jackson, Mrs. Susie Evelyn | | | | | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Jackson, Mrs. Susie | | Jackson | | Jackson | | Jackson | | Feb Month 17 Day 1969 Year | | 843 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Black | | 4/10/1889 | | 79 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | |
| Virginia | | U.S.A. | | | | D.H. Middlebrook Montgomery Md. | | Wheaton | | Univ. Ty Nursing School - Teacher | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| District of Columbia | | Washington, D.C. | | Washington, D.C. | | | | 722 9th St N.E., Wash. D.C. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Philip | | Smith | | Smith | | Smith | | Ellen | | Tucker | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Yes, no, or unknown | | 579-16-3810 | | BERNICE MITCHELL | | 5130 N. Capital St | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident | | 3 MONTHS | |
| | | | | | | | | 4369 | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | | | | | (b) Arterio-sclerotic vascular disease | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | | | | | (c) | | | |
| | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 7, 1968, to Feb. 17, 1969, that (I) (we) last saw the deceased alive on Feb. 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| Walter Gooch MD | | | | WALTER GOOCH MD | | 2309 SHOREFIELD RD WHEATON MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | Feb 20, 1969 | | Lincoln Mem. Cemetery | | Suitland Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Johnson Jenkins | | FEB 24 1969 | | James Judge | | | | | | | |

31030

12889

RECEIVED

NOV 10 1957

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

FILE: [Illegible]

NOTED: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| 02622 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 02617 | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|------------------|--|
| Item2 FilmG410 3/5/69 kk | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First Middle Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | |
| Thomas Paul Jackson Jr. | | | | February 12 1969 | | 8:40 P M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | 16 August 1943 | | 25 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Pennsylvania | | USA | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | The Clinical Center | | Employment Representative | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12000 Old Georgetown Road | | | |
| 14. FATHER'S NAME | | First Middle Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | | | | | |
| Thomas Paul Jackson | | | | Agnes Shevlin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| Yes | | 1965 | | The Medical Record | | The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | 1 Year | | | |
| IMMEDIATE CAUSE (a) Hepatic Failure | | | | | | | | | | | |
| 201X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Hodgkin's Disease | | | | | | | | 4 Years | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Pericarditis unknown etiology | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 Jan. 1969, to 12 February 1969, that (X) (we) last saw the deceased alive on 12 February 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| Robert E. Curran M.D. | | 13 February 1969 | | Robert E. Curran, M. D. | | The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| | | Feb. 17, 1969 | | Cathedral Cem. | | Scranton, Penna. | | | | | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| DeVol Funeral Home, | | 2222 Wisc. Ave. Wash. D.C. | | DATE 17 1969 | | William J. Under | | | | | |

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ENTRANCE OF HEATH

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CERTIFICATE OF DEATH

02623

02618

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|--|--|--|---------------|---|--|---|--|---|
| 1. DECEASED-NAME
(Type or print) | | First
FLORENCE | Middle
MAE | Last
JACOBS | 2a. DATE OF DEATH
Month Day Year
February 1, 1969 | | 2b. HOUR
2:30 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
February 12, 1892 | | 6. AGE (In years
lost birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
District of Columbia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | |
| 10. CITY OR TOWN OF DEATH
Olney, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Montgomery General Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Secretary | | 12b. KIND OF BUSINESS OR
INDUSTRY
Government | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3622 Gleneagles Drive |
| 14. FATHER'S NAME
First Middle Last
Levi Kidwell | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Minnie White | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Mr. James J. Jacobs | | Address
same as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident
4369 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hours
Years. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerosis Heart Disease | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1967, to 2/1, 1969, that (I) (we) last saw the deceased alive on 2/1/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Richard A. Yates MD | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/1/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
R. A. YATES | | | | 22e. ADDRESS
OLNEY, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb. 5, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Pr. Geo. Md. | | |
| 24. FUNERAL DIRECTOR
Arthur Walters, 254 Carroll St. New York City | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE FEB 6 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

INTERMEDIATE
Terminal
02619

| | | | | | | | | | | | |
|---|-------------------------|--|---|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) | | First
George | | Middle
U. | | Last
Johnson | | 2a. DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Day Feb. 4, Year 1969 | | 2b. HOUR
2:04 PM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
2-13-1908 | 6. AGE (In years last birthday)
60 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | 2c. DATE PRONOUNCED DEAD
Month Feb. Day 4 Year 1969 | | 2d. HOUR
9:20 AM | |
| 7a. BIRTHPLACE (State or foreign country)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | 10. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
12525 New Hampshire Ave. Arlington Heights, Ill. | | 11. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Army Colonel | |
| 12. KIND OF BUSINESS OR INDUSTRY
9801 t. | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY
Montgomery Sil. Spr. | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
15502 Gallandet Avenue | |
| 14. FATHER'S NAME
First Victor Middle -- Last Johnson | | 15. MOTHER'S MAIDEN NAME
First Katherine Middle -- Last Domish | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
475-16-2884 | | 17. INFORMANT
Helen A. Johnson | | ADDRESS
Sil. Spr., Md. 15502 Gallandet Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pylonephritis - Terminal
3480
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cachexia - Terminal
DUE TO, OR AS A CONSEQUENCE OF
(c) Amiotrophic Lateral Sclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Week
Months
Yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carcinoma Prostate: 3480 Aortic valvular Insuff. - (Ch. X. Sclerotic) (H. 11) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
BPR | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. DATE SIGNED
Feb. 5, 1969 | | 22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Beldan Reap, DME | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2-6-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | 24. FUNERAL DIRECTOR
C. Glen Carter | | 25a. REC'D BY REGISTRAR
Warner E. Pumphrey, Inc., 8434 Georgia Avenue | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
FEB 10 1969 | | 25d. ADDRESS
Sil. Spr., Md. | | 25e. ADDRESS
Sil. Spr., Md. | | 25f. ADDRESS
Sil. Spr., Md. | | 25g. ADDRESS
Sil. Spr., Md. | |

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Journal of Management Inquiry 18(6)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>ELMER E. JONES</u> | | | | | 2a. DATE OF DEATH
Month <u>2</u> - Day <u>24</u> - Year <u>69</u> | | | 2b. HOUR <u>10:15</u> A M | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>NEGRO</u> | | 5. DATE OF BIRTH
<u>JAN 4, 1888</u> | | 6. AGE (In years lost birthday) <u>81</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) <u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>MONTGOMERY</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>POOLESVILLE</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Rural</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RETIRED</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u> | | 13b. COUNTY <u>MONTG.</u> | | 13c. CITY OR TOWN <u>POOLESVILLE</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <u>JONESVILLE, RD</u> | |
| 14. FATHER'S NAME First <u>HENRY</u> Middle <u>JONES</u> Last <u>JONES</u> | | | 15. MOTHER'S MAIDEN NAME First <u>MIRAH</u> Middle <u>PETERS</u> Last <u>PETERS</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS HANNAH JONES</u> | | Address <u>POOLESVILLE, MD</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u>
<u>4379</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebro Vascular Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF
(c) <u>YEARS</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>28 Dec, 19 49</u> , to <u>24 Feb, 19 69</u> , that (I) <u>did</u> last saw the deceased alive on <u>31 Jan 1969</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Gordon Murdoch Smith MD</u> | | DEGREE <u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>24 Feb 69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Gordon Murdoch Smith MD</u> | | 22e. ADDRESS <u>Barter, Nr, Md 20703</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>2-27-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ELIJAH CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>POOLESVILLE, MONTG, MD</u> | | | |
| 24. FUNERAL DIRECTOR <u>ROBERT L. SNOWDEN</u> | | ADDRESS <u>ROCKVILLE, MD</u> | | 25a. REC'D BY REGISTRAR <u>MAR 4 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

03030

03030

DEATH CASE # 10111

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Cleared with medical examiner QB.
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02626

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

02621

| | | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Harry Leo Jones | | | 2a. DATE OF DEATH
Month February Day 8 Year 1969 | | | 2b. HOUR 4:05 P M | | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH April 14, 1889 | | 6. AGE (In years last birthday) 79 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12200 Remington Drive | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Attorney | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 12200 Remington Drive | |
| 14. FATHER'S NAME First Leander Lewis Middle Newton Last Jones | | | 15. MOTHER'S MAIDEN NAME First Carrie Middle -- Last Sterns | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 215 46 2410 | | 17. INFORMANT Address Saline W. Jones 12200 Remington Drive, S.S. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular Accident
4124 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 53 , to Feb 8 , 19 69 , that (I) (we) last saw the deceased alive on Feb 8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Raymond Bradshaw, MD DEGREE MD | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Feb. 8, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) Raymond Bradshaw | | | | | | 22e. ADDRESS 345 University Blvd, W Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 3-11-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Md. | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue ADDRESS Silver Spr. Md. | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 17 1969 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

13380

RAMIRO A. CRISTO

P3380

02627

02622

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
HOLY CROSS HOSPITAL | | | | d. STREET ADDRESS
11901 XXXX GEORGIA AVE. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First LAWRENCE Middle F Last JUDGE | | | | 4. DATE OF DEATH
Month FEB Day 6 Year 1969 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1887
SEPT 2 1897 | | 9. AGE (In years last birthday)
81 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
RETIRED | | 11. BIRTHPLACE (State or foreign country)
WASH D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
JOHN JUDGE | | | | 14. MOTHER'S MAIDEN NAME
CATHERINE FINNERAN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16. SOCIAL SECURITY NO.
WWT | | 17. INFORMANT
CATH. HOBBS. Address -1902 LONGMEAD ST. SP. MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
4109 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular disease
DUE TO
(c) 5 yrs
INTERVAL BETWEEN ONSET AND DEATH
24 mo. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7/2 , 19 69 , to Feb. 6 , 19 69 , that I last saw the deceased alive on 2/6 , 19 69 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.
ACTUAL SIGNATURE Myron L Lenden M.D. 2309-SHOREFIELD RD. DATE SIGNED 2/7/69
PHYSICIAN'S NAME (Type) WHEATON, MD. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
2/10/69 | | 22c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK | | 22d. LOCATION (City, town, or county) (State)
WASH. D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Horton Funeral Home | | | | ADDRESS
4748 WINE AVE. NW | | 24a. REC'D BY REGISTRAR
FEB 11 1969 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| COUNTY OF MONTGOMERY | | CITY OF BALTIMORE | |
| DECEASED JAMES EARL RAY | | DATE OF DEATH MAY 14 1968 | |
| PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION | | TIME OF DEATH 11:00 AM | |
| SEX MALE | | AGE 35 | |
| RACE WHITE | | HEIGHT 5' 11" | |
| WEIGHT 175 | | BUILD SLIM | |
| OCCUPATION ATTORNEY | | MARITAL STATUS SINGLE | |
| PLACE OF BIRTH MOBILE, ALABAMA | | DATE OF BIRTH MAY 14 1933 | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |
| SIGNATURE OF DECEASED [Signature] | | SIGNATURE OF WITNESS [Signature] | |
| SIGNATURE OF PHYSICIAN [Signature] | | SIGNATURE OF CORONER [Signature] | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH RECORD ACT OF 1965.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|---|---|---|--|---|---|---|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Camille M. Kearney | | | First Middle Last | | | 2a. DATE OF DEATH
Month February Day 18 Year 1969 | | | 2b. HOUR
7:20 P M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10-30-1906 | | | 6. AGE (In years
lost birthday)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
LUHETON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Wheaton Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) CLERICAL | | | 12b. KIND OF BUSINESS OR
INDUSTRY REPT. STORE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4207 Aspen Hill Road | | |
| 14. FATHER'S NAME
First HAROLD Middle RINGE Last N. A. | | | 15. MOTHER'S MAIDEN NAME
First N. A. Middle N. A. Last N. A. | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
220-38-3363 | | 17. INFORMANT
Address 4207 ASPEN HILL RD. ROCKVILLE, MD.
R. HARRY KEARNEY, SON, | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant Cachexia
180X
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma Cervix with Pelvic metastasis
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
90 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 15, 1968 , to Feb 18, 1969 , that (I) (we) lost
saw the deceased alive on Feb 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Stanley Bialek MD DEGREE | | | | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
18 Feb 69 | | | |
| 22d. PHYSICIAN'S
NAME (Type) Stanley Bialek | | | | | | 22e. ADDRESS
8218 Wisconsin Ave. Bethesda Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
2-20-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Prince Georges Co. Md. | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., ADDRESS
N.W., Wash., D.C., 20016 | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 21 1969 | | 25b. REGISTRAR'S SIGNATURE
Richard Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02629

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02624

| | | | | | | | | | |
|--|---------------|---|---|---|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or Print) <u>James Lewis Keith</u> | | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Feb 2 1969 | | | | 2b. HOUR
1:15 AM | |
| 3. SEX
M. | 4. RACE
W. | 5. DATE OF BIRTH
Aug. 19, 1914 | 6. AGE (In years
last birthday)
54 YRS. | IF UNDER 1 YEAR
MONTHS OAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Feb Day 2 Year 1969 | |
| 7a. BIRTHPLACE (State or foreign
country) <u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Rockville</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <u>811 Viers Mill Rd.</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<u>Truck driver</u> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <u>Md.</u> | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Rockville</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>811 Viers Mill Rd.</u> | |
| 14. FATHER'S NAME First Middle Last
<u>Jabe Keith</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>Melissa Hylton</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT ADDRESS
<u>Mr. Jabe Keith Father Willis, Va.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Heart.</u>
955X
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>3 min.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <u>1:15 P.M. Feb 2 1969</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Shot self in chest - 22 cal. R. fl.</u> | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
<u>Apartment Bldg</u> | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>811 Viers Mill Rd. Rockville Montgomery Md.</u> | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Feb. 2, 1969</u> | | | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 7936 Old Georgetown Rd. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) <u>Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<u>2/5/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Keith Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Floyd County Virginia</u> | | | |
| 24. FUNERAL DIRECTOR <u>Arnell H. Morn</u> ADDRESS
<u>3901 No. Fairfax Arlington, Va.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 6 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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CONFIDENTIAL - NOT FOR PUBLICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) BEARNIE | | | First F. | | | Middle F. | | | Last KENENGER | | | 2a. DATE OF DEATH Month Feb Day 15 Year 1969 | | | 2b. HOUR 12:00 AM | | |
| 3. SEX F | | | 4. RACE W | | | 5. DATE OF BIRTH 4-25-89 | | | 6. AGE (In years last birthday) 79 YRS. | | | IF UNDER 1 YEAR MONTHS 9 DAYS 20 | | | IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Indiana | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH Montgomery | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2002 CEDAR WAY | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Bethesda | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 2002 Cedar Way | | | | | |
| 14. FATHER'S NAME First UNKNOWN | | | Middle Bauer | | | Last UNKNOWN | | | 15. MOTHER'S MAIDEN NAME First UNKNOWN | | | Middle Linihan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO. UNKNOWN | | | 17. INFORMANT Mr. C. B. Anfinson | | | Address 9202-Cedar Way, Bethesda, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thyroid carcinoma of the colon
153.8
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 25 Dec 1967 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 Dec 1967 , to 14 Feb 1969 , that (I) (we) last saw the deceased alive on 12 Feb 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Horace W. Bernton, MD | | | DEGREE MD | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED Feb 15, 1969 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HORACE W. BERNTON, | | | 22e. ADDRESS Bethesda, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | | 23b. DATE 2-15-69 | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | | 23d. LOCATION (City or Town) (County) (State) Suitland Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey | | | ADDRESS 7557-Wisconsin Ave., Bethesda, Md. | | | 25a. REC'D BY REGISTRAR DATE FEB 17 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |

MEDICAL CERTIFICATION

02880

02880

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Tse</i> <i>Min</i> <i>Kiang</i> | | | 2a. DATE OF DEATH
Month <i>February</i> Day <i>26</i> Year <i>1969</i> | | | 2b. HOUR
<i>7:50 PM</i> | | | | | |
| 3. SEX
<i>MALE</i> | | | 4. RACE
<i>ORIENTAL</i> | | | 5. DATE OF BIRTH
<i>19 November 1913</i> | | | 6. AGE (In years last birthday)
<i>55</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>China</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>China</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Grosvenor Lane Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>LAWYER</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | 13b. COUNTY <i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Takoma Park</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
<i>1004 Houston Ave.</i> | | | 14. FATHER'S NAME First <i>CHI</i> Middle <i>H</i> Last <i>SUN</i> | | | 15. MOTHER'S MAIDEN NAME First <i>WEI</i> Middle <i>-</i> Last <i>SEZ</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>NA</i> | | | 17. INFORMANT
<i>ANDREW KIANG</i> | | | Address
<i>9411 AVENUE RD. SILVER SPRING</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>PULMONARY HEMORRHAGE</i>
<i>0119</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>PULMONARY TUBERCULOSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 MIN.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>ARTERIOSCLEROSIS - GENERAL</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/18</i> , 19 <i>69</i> , to <i>2/26</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/25/69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Ronald W. Barr, M.D.</i> | | | DEGREE <i>M.D.</i> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>2/26/69</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>RONALD W. BARR, MD</i> | | | 22e. ADDRESS
<i>10401 OLDGEORGETOWN RD BETHESDA</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>March 1, 1969</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>National Memorial Park</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Falls Church Va.</i> | | |
| 24. FUNERAL DIRECTOR
<i>Takoma Funeral Home</i> | | | ADDRESS
<i>Washington, D.C. 20012</i> | | | 50. REC'D BY REGISTRAR
<i>DATE FEB 28 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Helenas Yngre</i> | | |

MEDICAL CERTIFICATION

02001

CERTIFICATE OF DEATH

02001

10 min

Primary Hemorrhage
Primary Testicular

Posteriorly - 1st 2nd

2/18 of 2/22

2/22/22

1000 1000 1000

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15
30M REV. 11-68

| 02632 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02627 | | | | | | | | | |
|--|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------|--|--|---|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| KENNEY, Addie | | | | | | | | | | 2 Month 8 Day 1969 Year | | | | | | | | | | 2:00 p.m. | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| F | | | N | | | 9/26/78 | | | 90 YRS. | | | MONTHS | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Richmond, Va. | | | USA | | | | | | MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| WHEATON Md | | | | | UNIVERSITY HOME NURSING HOME | | | | | unemployed | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| WASHINGTON D.C. | | | | | D.C. | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 4020-LIVINGSTON Rd. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| John Baugh | | | | | Elizabeth (unknown) | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | MRS. HELEN HUMPHRIES 4020 LIVINGSTON RD WASH D.C. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 402X | | | | | | | | | | | | | | | 1 month | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) CVA & coma & pt. pneumonia | | | | | | | | | | | | | | | 1 month | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Hypertensive cardiac disease | | | | | | | | | | | | | | | unknown | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1969, to Feb 8, 1969, that (I) (we) last saw the deceased alive on Jan 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | |
| HENRY G. HADLEY MD | | | | | | | | | | | | | | | | | | | | Feb 8 69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 4601 Nichols Ave SW | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 02/13/69 | | | | | Harmony Memorial Park | | | | | Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Stewart Funeral Home-4001 Benning Road | | | | | | | | | | DATE FEB 13 1969 | | | | | | | | | | Charles J. [Signature] | | | | | | | | | |

MEDICAL CERTIFICATION

05380

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05380



05380 05380 05380 05380 05380 05380 05380 05380 05380 05380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

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|---|------------------------------|--|--|--|--|
| 02633 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 02628 | |
| Item 5 Film 409 2/21/69 kk | | | | | |
| 1. DECEASED-NAME (Type or print) | | | 2a. DATE OF DEATH | | 2b. HOUR |
| First Middle Last
ELIZABETH M. KURFESS | | | Month Day Year
FEB 6 1969 | | 105 M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS |
| FEMALE | WHITE | 12/2/1887 | | 81 YRS. | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | |
| N.J. | U.S.A. | | MONTGOMERY Md | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | | SUBURBAN | | housewife | own home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| MARYLAND | | MONTGOMERY | Silver Spring | | 4204 Tabbell St. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| Michael -- ADAMS | | | MARGARET -- McKENNA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (or unknown) | | yes | ELYNOR K. CREGAR - Daughter - same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Congestive Heart Failure 2 weeks 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Electrolyte Imbalance 1 wk (c) Hypertensive Cardiovascular Dis 4R 5 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive mild anemia, Rheumatoid Arthritis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1968, to 2/6, 1969, that (I) (we) last saw the deceased alive on 2/6 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| Raymond T. Benack MD | | 2/6/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Raymond T. Benack MD | | 4115 Edie Dr Wheatridge | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | 2-10-1969 | Clinton Cemetery | | Drwington Essex New Jersey |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Oak Grove | | Sil. Spr. Md. | | DATE FEB 10 1969 | William J. Judge |
| Warner E. Pumphrey, Inc. 8434 Georgia Ave. | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>Ralph</u> First <u>Laing</u> Middle <u>Laing</u> Last | | | | | 2a. DATE OF DEATH <u>2</u> Month <u>28</u> Day <u>69</u> Year | | 2b. HOUR <u>6:45</u> M | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>11-23-03</u> | | 6. AGE (In years last birthday) <u>65</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>VA.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>PAINTER</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Lohn Decor.</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u> | | 13b. COUNTY <u>Mont.</u> | | 13c. CITY OR TOWN <u>Gaithersburg</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>401 G. Diamond Ave.</u> | |
| 14. FATHER'S NAME First <u>ASHBY</u> Middle <u>LAING</u> Last | | | 15. MOTHER'S MAIDEN NAME First <u>RENER</u> Middle <u>MATHEWS</u> Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT <u>ELEANOR M. SHREFFLER</u> | | Address <u>19027 FREDERICK AVE. GAITHERSBURG, MARYLAND</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm, ruptured, anterior communicating branch</u> | | | | | | | | | |
| 4309 DUE TO, OR AS A CONSEQUENCE OF <u>Circle of Willis, congenital</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension, Emphysema, Pneumonia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>Feb. 24</u> , 19 <u>69</u> , to <u>Feb 28</u> , 19 <u>69</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>Feb 27</u> , 19 <u>69</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(1)</u> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>James R. Moore</u> MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>Feb 28, 1969</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS <u>570 N. Frederick Ave. Gaithersburg, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>3-3-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>FRONT ROYAL VA.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Md.</u> ADDRESS | | | | | 25a. REC'D. BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 4 1969</u> | | 25b. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

23030

23030

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
WASHINGTON, D. C.

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
WASHINGTON, D. C.

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RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 02635 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02630 | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---|--|---|--|--|-----------------------------|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
Serena Emma Lamb | | | | | | | | | | Month Day Year
2 3 69 | | | | | | | | | | 11 35 A M | | | | | | | | | |
| 3. SEX
Female | | | 4. RACE
white | | | 5. DATE OF BIRTH
Dec. 13, 1882 | | | 6. AGE (In years last birthday)
86 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Wash. D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Althea Woodland Hosp. 1000 Daleview Dr. Silver Spring, Md. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Billie Engraving & Printing | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Mont. | | | 13c. CITY OR TOWN
Takoma Park. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
7520 Maple Ave. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Daniel C. Greenwell | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Serena Margaret Pfeiffer | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
578-62-7052 | | | 17. INFORMANT
Marion Greenwell | | | Address
7520 Maple Ave. Takoma, Pk., Md. | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4339 Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>General arterio sclerosis</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
5 yrs.
indeterminate | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19, 1969, to Feb 3, 1969, that (I) (we) last saw the deceased alive on Jan 19, 1969, and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above, (I) (we)(did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
L.W. Malon M.D. | | | 22c. DATE SIGNED
2-3-69 | | | 22d. PHYSICIAN'S NAME (Type)
L.W. Malon M.D. | | | 22e. ADDRESS
Riverdale Md. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
Feb. 5, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Suitland Bk. Md. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Takoma Funeral Home | | | | | | | | | | 25. REGISTRY BY REGISTRAR
FEB 6 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

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RECEIVED BY MAIL

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RECEIVED BY MAIL

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Item 5 Film 410 3/11/69 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 02636 | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | |
| Reginald Ross Leake | | | | | | | | | | March 3, 1969 | | | | | | | | | |
| 3. SEX | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Male | | | | | | | | | | M | | | | | | | | | |
| 4. RACE | | | | | | | | | | 2c. DATE PRONOUNCED DEAD | | | | | | | | | |
| Cauc | | | | | | | | | | Month Day Year | | | | | | | | | |
| Jan. 29, 1969 | | | | | | | | | | March 3, 1969 | | | | | | | | | |
| 5. DATE OF BIRTH | | | | | | | | | | 2d. HOUR | | | | | | | | | |
| 1940 | | | | | | | | | | P.M. | | | | | | | | | |
| 6. AGE (In years last birthday) | | | | | | | | | | 2e. COUNTY OF DEATH | | | | | | | | | |
| 29 YRS. | | | | | | | | | | Montgomery | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| Virginia | | | | | | | | | | Montgomery | | | | | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 10. CITY OR TOWN OF DEATH | | | | | | | | | |
| U.S.A. | | | | | | | | | | Takoma Park, | | | | | | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | |
| | | | | | | | | | | 7034 Carroll Ave. Apt 1 | | | | | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Painter | | | | | | | | | | Houses | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | |
| Maryland | | | | | | | | | | Montgomery | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | |
| Takoma Park | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 13e. STREET AND NUMBER | | | | | | | | | | 7034 Carroll Avenue | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | | | | | | | | First Middle Last | | | | | | | | | |
| Not available | | | | | | | | | | Not available | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| Yes | | | | | | | | | | 1960-1962 | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | |
| Takoma Park Police | | | | | | | | | | Takoma Park Md | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Sunshot wound in | | | | | | | | | |
| 955X | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Head with Exsanguination, | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | | | | | | | (c) Self-inflicted | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY? | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year | | | | | | | | | |
| CAUSE OF DEATH | | | | | | | | | | HOUR A.M. P.M. 2-24 1969 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | Home | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. | | | | | | | | | | City or Town | | | | | | | | | |
| 7034 Carroll Ave. | | | | | | | | | | Tak. Pk. Montgom. Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 22b. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| March 4, 1969 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| Burial 3-5-69 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| | | | | | | | | | | Wilkes Memorial Cemetery | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. RECEIVED BY REGISTRAR | | | | | | | | | |
| George Funeral Home by the day Cal papers Va | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | | | | | | | | | March 6 1969 | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | |
|---|--|--|--------|---|-------------------------------------|---|----------------|--------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
PM | |
| Louise | | | (NMN) | Lee | February 18 1969 | | 8:30 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Female | | Negro | | 1 January 1906 | | 63 YRS. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Virginia | | USA | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | The Clinical Center, NIH | | Domestic | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Washington, D.C. | | | | Washington, D.C. | | | | 1817 Riggs Place, N.W. |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| Mason | | Carter | | Minnie Lambert | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | Not Available | | Bethesda, Maryland 20814
The Medical Records, The Clinical Center, | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cardiac arrest</u>
<u>4100</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Acute coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension and arteriosclerotic heart disease</u> years
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>11 hours</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>18 February, 1969</u> , to <u>18 Feb.</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>18 February</u> 19 <u>69</u> , and that in <u>1969</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>R. E. Miller, M.D.</u>
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
<u>19 February 1969</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
Richard E. Miller, M.D. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| | | <u>2-22-69</u> | | <u>Harmeny memo. park</u> | | <u>Landover</u> | | <u>Md</u> |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| <u>Crouch's Funeral Home</u> | | <u>5501-8th St. N.W.</u> | | <u>MAR 11 1969</u> | | <u>Charles Judge</u> | | |

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STATE OF NEW YORK

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| | | | |
|---|--|---------------|--|
| No. 1000 | | Date 10/10/10 | |
| To the Honorable | | The Governor | |
| of the State of New York | | at Albany | |
| I, the undersigned, do hereby certify that | | | |
| the within and foregoing is a true and correct copy | | | |
| of the original as the same appears from the records | | | |
| of the State of New York. | | | |
| In witness whereof, I have hereunto set my hand and | | | |
| affixed the seal of the State of New York, at Albany, | | | |
| this 10th day of October, 1910. | | | |
| J. B. [Signature] | | | |
| [Seal] | | | |

THIS DOCUMENT CONTAINS NEITHER RECOMMENDATIONS NOR
CONCLUSIONS OF THE NATIONAL BUREAU OF STANDARDS
AND IS INTENDED TO PRESENT THE RESULTS OF INVESTIGATIONS
CONDUCTED BY ITS PERSONNEL OR BY OTHERS UNDER CONTRACT
WITH THE BUREAU. IT IS THE POLICY OF THE BUREAU TO
MAKE AVAILABLE TO THE PUBLIC THE RESULTS OF ITS RESEARCH
WORK.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | |
| Boy | | | | | | Lieberson | | Feb. Month 21 Day 1969 Year | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 2b. HOUR | |
| m | | w | | 2-19-69 | | 21 | | 1 3/4 M | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| md. | | USA | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MONTGOMERY | | MONTGOMERY | | Cherry Chase | | | | 3231 Coagelin Terrace | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Joseph m. Lieberson | | Ann Lieberson | | | | | | Joseph Lieberson - FATHER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. CAUSE OF DEATH | | 20. CAUSE OF DEATH | | 21. CAUSE OF DEATH | | 22. CAUSE OF DEATH | |
| PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| 740X | | Anencephaly | | | | Congenital malformation | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-19, 1969, to 2-21, 1969, that (I) (we) lost saw the deceased alive on 2-21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. ADDRESS | | | | | |
| Elizabeth Chickering | | 3601 Connecticut Ave. | | Washington, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 2/21/69 | | Suburban Hospital | | Bethesda, Montgomery MD | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Mrs. Amelia C. Carter, Administrator | | DATE FEB 25 1969 | | Richard Judge | | | | | |

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|------------------------------|--|--|-----------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> 02639 02634 </div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| MARION JEAN LOCKRIDGE | | | | | | <input checked="" type="checkbox"/> Month Day Year
<input type="checkbox"/> ESTI- MATED <u>Feb. 5</u> 19 <u>69</u> | | | <u>12</u> M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Female | White | May 10, 1913 | 55 YRS. | MONTHS 8 DAYS 26 HOURS MIN. | | Month Day Year
<u>Feb.</u> <u>5</u> 19 <u>69</u> | | | <u>12</u> M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Penna. | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Rockville | | | Potomac Valley Nursing Home | | | Cosmetician | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. STREET AND NUMBER |
| Md. | | | Montgomery | | | Bethesda | | | 5021 Bradley Blvd. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Harry A Edel | | | MARIE Zuecher | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| | | | 173-32-1433 | | | Terry L Lockridge | | | |
| | | | | | | ADDRESS 30 A RIVIS PARK TRIANGLE, VA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary - c Metastasis</u> | | | | | | | | | <u>Months</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| <u>John G. Ball</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | <u>Feb-5, 1969</u> | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | |
| JOHN G. BALL, M.D. | | | | | | Montgomery Co. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | Feb, 7, 1969 | | | Parklawn Cemetery | | | Rockville, Mont Md. |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE |
| Robert A Pumphrey | | | 7557 Wisconsin Ave Bethesda, Md | | | FEB 10 1969 | | | <u>Charles Judge</u> |

02001

02001

SECTION EXAMINER'S CERTIFICATE OF DEATH

LOCKRIDGE

1944

MAY 10, 1944

General White May 10, 1944

Rockwood Valley Nursing Home

Rockwood

1944

JOHN O. BALL, M.D.

ROCKWOOD VALLEY NURSING HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

| 02640 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02635 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|---|--|------------------------|--|--|------------------|--|--|-------|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| ANTOINETTE C. LOMBERG | | | | | | | | | | FEB 24 1969 | | | | | | | | | | 6 29 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| FEMALE | | | WHITE | | | 6/22/89 | | | 79 YRS. | | | MONTHS | | | DAYS | | | HOURS | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| GERMANY | | | USA | | | | | | MONTGOMERY | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| BETHESDA | | | SUBURBAN | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| MARYLAND | | | MONTGOMERY | | | ROCKVILLE | | | | | | 199 ROLLINS AVE. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EDMUND VOM STEEG | | | Emilie PICARD | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| No | | | 088-05-0655A | | | IRMA WEIDOWKE-DAUGHTER | | | 6005 CONWAY RD - BETHESDA, MD | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>generalized atherosclerosis + thromboembolism</u> | | | | | | | | | | 10 days | | | | | | | | | | | | | | | | | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) <u>ca. head ab pneumonia</u> | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 FEB</u> , 19 <u>69</u> , to <u>24 FEB</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>24 FEB</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | 2/25/69 | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Robert M. Wynn | | | 7801 NORFOLK AVE., Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| Burial | | | 2-27-69 | | | Fairmont Cemetery | | | Newark, New Jersey | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REGISTERED | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | FEB 28 1969 | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

02832

02832



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

02641

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02636

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) James Frederick Luper | | | 2a. DATE OF DEATH
Month February Day 17 Year 1969 | | | 2b. HOUR 4:20 P M | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
5 July 1915 | | 6. AGE (In years
last birthday)
53 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign
country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Mechanic | | | 12b. KIND OF BUSINESS OR
INDUSTRY
U.S. Govt. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
529 West Montgomery Ave. | | |
| 14. FATHER'S NAME First James Middle H. Last Luper | | | 15. MOTHER'S MAIDEN NAME First Eula Middle Proctor Last Proctor | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
238-12-4564 | | 17. INFORMANT The Medical Record Address
The Clinical Center, NIH, Bethesda, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
1621
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. }
(b) Cardiac and Renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Recurrent squamous cell carcinoma with metastases/
to lung
3 months | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 days
1 day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/11/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer of right lung | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 19 Day 19 Year 19
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 Jan. , 19 69 , to 17 Feb. , 19 69 , that <input checked="" type="checkbox"/> (we) last
saw the deceased alive on 17 February 19 69 , and that in our opinion death occurred on the date and hour and from the
causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Everett V. Sugarbaker M.D. | | 22c. DATE SIGNED
17 February 1969 | | 22d. PHYSICIAN'S
NAME (Type) Everett V. Sugarbaker, M.D. | | | | | | | |
| 22e. ADDRESS
The Clinical Center, National
Institutes of Health, Bethesda, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
2/20/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home-1331 | | ADDRESS
Rockville, Md. | | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

02642

02637

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--------------------------|--|------------------|--|--------|--|------|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | Month | | Day | | Year | | 2b. HOUR | |
| | | Charles | | Eldridge | | Lynn | | February | | 12 | | 12 | | 1969 | | 11 ¹⁰ A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| Male | | White | | July 7, 1907 | | 61 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | | |
| Virginia | | America | | | | Montgomery | | | | | | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Takoma Park | | Washington Sanitarium | | Carpenter | | self employed | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | Montgomery | | Burtonsville | | | | 4800 Sandy Spring Road | | | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | | | |
| | | Charles | | Lynn | | | | Susan | | Frics | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | | | | | |
| no | | 587-10-5307 | | Patient's chart | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) _____ | | | | | | | | | | | | | | | | minutes | |
| 1621 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| Pulmonary emphysema | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 9-17-68 | | BRONCHOGENIC CARCINOMA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | | | | |
| While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT, 1968, to FEB, 1969, that (I) (we) last saw the deceased alive on FEB, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | | | | | | | |
| Kenneth Cruz | | 5 FEB 1969 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | | | |
| Burial | | 2/8/69 | | Ft Lincoln Cem | | Colman Manor Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Cannedran Funeral Home, Laurel | | FEB 10 1969 | | Charles Judge | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>Joseph</u> | | | First <u>S.</u> Middle <u>Mammela</u> Last | | | 2a. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1969</u> | | | 2b. HOUR <u>6:40</u> M <u>A</u> | | |
| 3. SEX <u>male</u> | | | 4. RACE <u>White</u> | | | 5. DATE OF BIRTH <u>December 8th 1888</u> | | | 6. AGE (In years last birthday) <u>80</u> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Delaware</u> | | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | |
| 10. CITY OR TOWN OF DEATH <u>Olney</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Bancker Care Foundation</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Salesman</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | | 13b. COUNTY <u>Montgomery</u> | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER <u>Rt 2</u> | | |
| 14. FATHER'S NAME First <u>Charles</u> Middle <u>C</u> Last <u>Mammela</u> | | | 15. MOTHER'S MAIDEN NAME First <u>Johanna</u> Middle <u>Stoeckle</u> Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <u>No</u> (If yes give war or dates of service) <u>--</u> | | | 16b. SOCIAL SECURITY NO. <u>518-05-0500</u> | | |
| 17. INFORMANT <u>Anta M. Zeiler</u> | | | Address <u>1001 Rockville Pike - Rockville, Md.</u> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Ischemic Premonition</u> | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Brain Syndrome</u> | | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular C-V Disease</u> | | | <u>3 days</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 21, 1968</u> , to <u>2/21, 1969</u> , that (I) (we) last saw the deceased alive on <u>2/20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | 22c. PHYSICIAN'S NAME (Type) <u>C. H. L. GON</u> | | | 22d. ADDRESS <u>SANDY SPRING MD 20860</u> | | | 22e. DATE SIGNED <u>2/21/69</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE <u>2-24-1969</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Rockville Montgomery Md.</u> | | |
| 24. FUNERAL DIRECTOR <u>C. Glen Carter</u> | | | ADDRESS <u>Sil. Spr., Md.</u> | | | 25a. REC'D BY REGISTRAR <u>[Signature]</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |
| 26. FUNERAL HOME <u>Warner E. Pumphrey, Inc.</u> | | | ADDRESS <u>8434 Georgia Avenue</u> | | | DATE <u>FEB 26 1969</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be cleared with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEAR WITH MEDICAL EXAMINER

MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|---------|--|------------------|---|-------------------------------------|--|--------------------------------|---|---------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| Philip | | NMI | Mankowitz | | 2 Month 10 Day 69 | | 2:03P | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | White | | 4/15/07 | | 61 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Baltimore Md. USA | | | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | merchant | | merchant | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Sil. Sprg. | | | | 8484 16th St. SSMD. | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost |
| Barney | | | | | Nettie | | | | Kramer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| none | | | | wife Mary | | 8484 16th St. SS, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>582X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Arteriosclerotic Hypertensive CVD</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic glomerulonephritis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 yrs.</u>
<u>45 yrs.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 8, 1956</u> , to <u>Feb 10, 1969</u> , that (I) (we) last saw the deceased alive on <u>Dec 31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Arthur S. Bresler, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
<u>Feb. 10, 1969</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER, M.D.</u> | | | | | | 22e. ADDRESS
<u>10881 LOCKWOOD DR-S.S.-MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| BURIAL | | 2-12-69 | | KING DAVID MEMORIAL GARDEN | | FALLS CHURCH | | VA. | |
| 24. FUNERAL DIRECTOR
<u>BERNARD DANZANSKY & SONS - WASHINGTON DC</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 14 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William A. Dodge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|------------------------------|--|--|------------------------------------|---|--|---|--|--|------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| ALICE ETHEL MARCUS | | | | | | Feb. Month 6 Day 1969 Year | | | 12 ⁵⁸ M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| FEMALE | | WHITE | | Aug. 15, 1884 | | | 84 YRS. | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | | | | |
| New Jersey | | U. S. A. | | | | Montgomery | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Albany | | | BROOKE GROVE Foundation | | | Housewife | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | Pr. Geo. | | Mitchellville | | YES | | Enterprise Rd. | | 3200- | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| George HANCOX | | | Elizabeth P. Pearson | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| No | | | 679-24-9321A | | | Edward R. Marcus - field Dr. | | | 1108-Brent- | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) BASILAR ARTERY HEMORRHAGE | | | | | | | | | 12 HRS. | | | | | |
| 4124 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) CEREBRAL ARTERIOSELEPOSIS | | | | | | | | | YES. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) ASCVD. | | | | | | | | | YRS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| SENILITY: CHRONIC ORGANIC BRAIN SYNDROME: CHF. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/16, 1963, to 2/6, 1969, that (1) (we) last saw the deceased alive on 3/5, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | |
| Donald R. Lewis MD. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22c. DATE SIGNED 2/6/69. | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) DONALD R. LEWIS MD. | | | | | | | | | | | | | | |
| 22e. ADDRESS 700 COVERLY SILVER SPR, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | 2/8/69 | | Ft. Lincoln Cem. | | | Colmar Manor, Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Nalley's Funeral Home Inc. | | | | | | Mt. Rainier, Maryland | | FEB 10 1969 | | | | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|---|--|------------------------|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last
<i>Mary Jane Markowich</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Month Day Year
<i>2-12 1969</i> | | 2b. HOUR
<i>5:30 P.M.</i> | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>CAUC</i> | | 5. DATE OF BIRTH
<i>MAY 4 1939</i> | | 6. AGE (In years last birthday)
<i>29</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
<i>2-12 1969</i> | | 2d. HOUR
<i>5:30 P.M.</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Michigan</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>SILVER SPRING</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>HOLY CROSS HOSP</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Receptionist</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Pharmaceut. Association</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE
<i>Md.</i> | | | | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Sil. Spr.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>722 Pershing Drive</i> | | | |
| 14. FATHER'S NAME First Middle Last
<i>WEBSTER</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>ELNA 2 McEuffie</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO.
<i>380-40-1137</i> | | | | 17. INFORMANT ADDRESS
<i>L. Webster Madero 722 Pershing Drive, Sil. Spr. Maryland</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Multiple Extreme Internal</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Injuries incurred in</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>auto accident.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
<i>5:28 P.M. 2-12 1969</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
<i>Deceased in driver of auto which crossed midline & collided with auto</i> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<i>Street</i> | | | | 21f. LOCATION (Street or R.F.D. No.)
<i>E-W Hwy. & Rosemary</i> | | | | City or Town
<i>Sil. Spr.</i> County
<i>Montg.</i> State
<i>Md.</i> | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Belden R. Reap</i>
EXAMINER'S NAME (Type)
<i>BELDEN R. REAP, M.D.</i> | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, City, County)
<i>Feb. 12, 1969</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 23b. DATE
<i>2-18-1969</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State)
<i>Jackson, Michigan</i> | | | |
| 24. FUNERAL DIRECTOR
<i>C. Glen Carter</i> | | | | 25a. REC'D BY REGISTRAR
<i>Warner E. Pumphrey, Inc. Silver Spring, Maryland</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Feb 19 1969</i> | | | | | | | |

08042

MEDICAL EXAMINER, DEPARTMENT OF HEALTH

08042

DEATH CERTIFICATE

| | | | | | | | | | |
|-----------------------|--|-------------------------|--|----------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | 1910-01-15 | | New York, N.Y. | |
| Cause of Death | | Disease | | Organ | | Site | | Nature | |
| Myocardial Infarction | | Coronary Artery Disease | | Heart | | Left Ventricle | | Atherosclerosis | |
| Time of Death | | Place of Death | | Occupation | | Marital Status | | Social Status | |
| 1950-01-20 | | Home | | Teacher | | Married | | Middle Class | |
| Signature of Examiner | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|---------------------------------|---|---|--|--------------|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | |
| WALTER | | | JAMES | | MARSHFIELD | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2a. DATE KNOWN OF DEATH MATED |
| MALE | WHITE | 4/14/86 | | 82 YRS. | | | | | <input checked="" type="checkbox"/> FEB 21 1969 |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| ENGLAND | | | U.S.A | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | | | SUBURBAN | | | MINISTER | | | RELIGION |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| MARYLAND | | | MONTGOMERY | | BETHESDA | | | | 8007 MAPLERIDGE RD |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME |
| WILLIAM | | | MARSHFIELD | | LYDIA | | MITCHELL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | | | SARAH MARSHFIELD - WIFE - SAME | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4124 CORONARY Insufficiency Acute
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardio Vascular Disease - years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | JOHN G. BALL | | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | JOHN G. BALL | | | | FEB 21, 1969 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 2/24/69 | | NATIONAL MEMORIAL PK. | | FALLS CHURCH, VA. | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| JOS. GAWLER'S SONS, WASHINGTON, D. C. | | | 5130 WIS. AVE., N. W. | | | FEB 26 1969 | | Thomas Judge | |

02020

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02020

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02648

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02643

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) Lillian First Martin Middle Lost | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Feb-3 19 69 Month Feb Day 3 Year 1969 | | | 2b. HOUR 12 AM | | | | | |
| 3. SEX Fe | | 4. RACE Negro | | 5. DATE OF BIRTH March 7 1907 | | 6. AGE (in years last birthday) 61 YRS. | | 7c. DATE PRONOUNCED DEAD
Month Feb Day 3 Year 1969 | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH Tobacco Town | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. #3 Gaithersburg | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Tobacco Town | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Unknown Middle Unknown Last Unknown | | | 15. MOTHER'S MAIDEN NAME First Came Middle Davis Last Davis | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Ball | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED Feb-3, 1969 | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 2-6-69 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem. | | | 23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md. | | | |
| 24. FUNERAL DIRECTOR Robert L. Snowden | | | | ADDRESS Rockville Md | | | | 25a. REC'D BY REGISTRAR Feb 10 1969 | | 25b. REGISTRAR'S SIGNATURE Robert L. Snowden | |

8250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02649

02644

| | | | | | | | | | | | |
|--|--|------------------------------|--|---|------------------------------------|--|---|---|--|--------|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Lottie Virginia Martin | | | | | | Month Day Year
Feb. 27, 1969 | | | 9:45 P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | July 15, 1898 | | | 70 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| W. Va. | | USA | | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Olney | | | Montgomery Gen. Hosp. | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| W. Va. | | | Pendleton | | Brandywine | | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Calvin T. Kiser | | | | | | Sarah Virginia Rexrode | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| No | | | | | | Mrs Mary Lee Harper, R#1, Gaithersburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia - ventricular fibrillation</i>
4124 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac irritability</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Atherosclerotic Cardiovascular disease</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2-12, 1969, to 2-17, 1969, that (1) (we) last saw the deceased alive on 2-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Milton D. Westberg M.D.</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
Feb 27, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) Milton D. Westberg, M. D. | | | | | | 22e. ADDRESS
431 N. Frederick Ave. Gaithersburg, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Mar. 1, 1969 | | Sugar Grove | | | Sugar Grove, W. Va. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Olin L. Molesworth, Damascus, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 3 1969 | | | 25b. REGISTRAR'S SIGNATURE
<i>Olin L. Molesworth</i> | | |

County of _____ State of _____

Know all men by these presents, _____

_____ of the County of _____ State of _____

do hereby certify that _____

_____ is the true and correct _____

_____ of the County of _____ State of _____

_____ and _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|--|--|---------|---|------------------|--|--|---------------------------------|--|--|--|------------------|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | | |
| MAY E. MC CARGAR | | | | | | Month FEB Day 1 Year 69 | | | 6:20 PM | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| Female | | White | | April 24, 1902 | | | 68 YRS. | | MONTHS | | OAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | | |
| Washington DC | | | USA | | | | | | Montgomery | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Silver Spring | | | Sylvan Manor Health Cen | | | Secretary | | | U S Gov't | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | |
| D.C. | | | 13b. COUNTY | | | Washington | | | | | | 1425 Rhode Island Ave NW | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | |
| Lawrence J Curtin | | | Mary - Flynn | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | |
| | | | | | | Theresa Bryant | | | 6299 Carson Ave Oxon Hill Md | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, | | | | | | | | | | | | 3 days | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) CHRONIC DEBILITATION, | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) GENERALIZED ARTERIO SCLEROSIS | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1969, to Feb 1, 1969, that (I) (we) last saw the deceased alive on Jan 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| Robert T. Thibadeau | | | | | | | | | | | | FEB 1-1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU | | | | | | | | | | | | 22e. ADDRESS | | | |
| ROCKVILLE, MARYLAND | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | 2-5-1969 | | | Mount Olivet Cemetery | | | Washington D C | | | | | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | | | | | | | | | | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 4308 Suitland Road Suitland Maryland | | | | | | | | | | | | FEB 5 1969 | | | |

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526 J. S. Iltis

310103 207118

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 3
45M - 11 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02651

02646

| | | | | | |
|---|---|--|--|--|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>Abbie J. McGinley</i> | | | 2a. DATE OF DEATH
Month <i>9</i> Day <i>69</i> Year <i>2</i> | | 2b. HOUR
<i>2:38</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>9/20/86</i> | | 6. AGE (In years lost birthday)
<i>82</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>Ireland Dundalk</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife own home</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Mont</i> | 13c. CITY OR TOWN
<i>Wheaton</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>11532 Soward Dr</i> |
| 14. FATHER'S NAME First Middle Last
<i>Richard -- Martin</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Mary -- Thrautsky</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>030-14-6645A</i> | | 17. INFORMANT
<i>James G. McGinley</i> Address <i>11532 Soward Dr. Wheaton Maryland</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Concussion of Tongue & Metastasis</i>
<i>141.9</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>18 months</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>1) Stricture of esophagus 2) Arteriosclerosis Heart disease</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) this hospital attended the deceased from <i>Sept 30, 1969</i> , to <i>Feb 9, 1969</i> , that (I) the last saw the deceased alive on <i>Feb 8</i> 19 <i>69</i> , and that in (my) the opinion death occurred on the date and hour and from the causes stated above, (I) did <i>did not</i> view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Michael M. Dobridge M.D.</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Feb 9, 1969</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Michael Dobridge, M.D.</i> | | 22e. ADDRESS
<i>9801 Georgia Avenue, Sil.Spr., Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>2-13-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven Cemetery</i> | |
| 23d. LOCATION (City or Town)
<i>Silver Spring</i> | | (County)
<i>Montgomery</i> | | (State)
<i>Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>C. Glen Carter</i> | | ADDRESS
<i>Maryland</i> | | 25a. REC'D BY REGISTRAR
<i>17 1969</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | 25c. REGISTRAR'S NAME
<i>Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S.</i> | | | |

05807

UNITED STATES OF AMERICA

05807

UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C. 20315
1-1-1969
MEMORANDUM FOR THE CHIEF OF STAFF
SUBJECT: [Illegible]
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99. [Illegible]
100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Rose | | | Middle
Williamson | | | Last
McGowan | | | 2a. DATE OF DEATH
Month
Feb. Day
26 Year
1969 | | | 2b. HOUR
1:30 P.M. | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
3-30-1876 | | | 6. AGE (In years
last birthday)
92 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Washington, D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Woodacres | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
5802 Ramsgate Road | | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
At home | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Woodacres | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
5802 Ramsgate Road | | | | | |
| 14. FATHER'S NAME
First
James | | | Middle
Williamson | | | Last
Williamson | | | 15. MOTHER'S MAIDEN NAME First
Mary | | | Middle
McGowan/correct/ | | | Last
McGowan/correct/ | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
579-60-0362 | | | 17. INFORMANT
Mrs. Elizabeth McGowan Fore, Daughter | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>
<u>4121</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>with hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>18 days</u>
<u>years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1963</u> to <u>Feb 25, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 25, 1969</u> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>C P Ryland</u> | | | | | | | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>2-26-69</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>4400-49 St N.W. C P RYLAND</u> | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE
<u>2-28-1969</u> | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | | 23d. LOCATION (City or Town)
<u>Washington, D.C.</u> | | | (County) (State) | | | | | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc., 5130 Wisconsin Ave. N.W., Wash., D.C., 20016</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 5 1969</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

74880

UNITED STATES DEPARTMENT OF AGRICULTURE

25000

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

TO THE HONORABLE THE SECRETARY

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

FOR THE PURPOSE OF

RECEIVING

YOUR OFFICE

OF THE

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

FOR THE PURPOSE OF

RECEIVING

YOUR OFFICE

OF THE

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

FOR THE PURPOSE OF

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YOUR OFFICE

OF THE

DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|---|--|---|---|-----------------|---|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
John | | Middle
W. | | Last
McManus | | 2a. DATE OF DEATH
Feb. Month 11 Day 69 Year | | 2b. HOUR
1155A
M | | |
| 3. SEX
Male | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
Jul. 5, 1914 | | | 6. AGE (In years
last birthday)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Indiana | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
U. S. Navy | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Virginia | | | 13b. COUNTY
Arlington | | | 13c. CITY OR TOWN
Arlington | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2001 Columbia Pike | | |
| 14. FATHER'S NAME
First
John | | | Middle
McManus | | | Last
McManus | | | 15. MOTHER'S MAIDEN NAME
First
Bessie | | | Middle
Daly | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
Yes | | | (If yes give war or dates of service)
1934-68 | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
Hospital records | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u>
<u>1929</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <u>Glioblastoma multiforme</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Oct. 14</u> , 1968, to <u>Feb. 11</u> , 1969, that (X) (we) last
saw the deceased alive on <u>Feb. 11</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>F. E. SENN, MD.</u> | | | | | | | | | | DEGREE
ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Feb. 12, 1969 | |
| 22d. PHYSICIAN'S
NAME (Type)
F. E. SENN, MD. | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
Feb. 14, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Arlington, Va | | | | | |
| 24. FUNERAL DIRECTOR
Covington Martin Funeral Home
Route 7, Arlington, Virginia | | | 25a. REC'D BY REGISTRAR
FEB 19 1969 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |

03029

03029

[The body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table structure, but the characters are too light to transcribe accurately.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|-------------------------|---|--|--|--|---|--|---|--|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First
<i>Emmanuel</i> | | Middle
-- | | Last
<i>Michael</i> | | 2a. DATE KNOWN OF DEATH
Month <i>Feb.</i> Day <i>10</i> Year <i>1969</i> | | 2b. HOUR
<i>12:15</i> PM | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>June 14, 1884</i> | | 6. AGE (in years last birthday)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS
HOURS _____ MIN. _____ | | 2c. DATE PRONOUNCED DEAD
Month <i>Feb.</i> Day <i>10</i> Year <i>1969</i> | 2d. HOUR
<i>12:15</i> PM |
| 7a. BIRTHPLACE (State or foreign country)
<i>Turkey</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Wheaton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Wheaton Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Nurse</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>restaurant</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Sil. Spr.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>9408 Woodland Drive</i> | | | |
| 14. FATHER'S NAME
First <i>(Unknown)</i> Middle <i>(Unknown)</i> Last <i>(Unknown)</i> | | | | 15. MOTHER'S MAIDEN NAME
First <i>(Unknown)</i> Middle <i>(Unknown)</i> Last <i>(Unknown)</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
<i>115-12-9675A</i> | | 17. INFORMANT
ADDRESS
<i>Helen Galanos 9408 Woodland Drive, Sil. Spr. Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <i>due to Cancer of the Prostate;</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arteriosclerosis, Generalized</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Belden R. Reap</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
<i>Feb. 10, 1969</i> | | | |
| EXAMINER'S NAME (Type)
<i>BELDEN R. REAP, M.D.</i> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county)
<i>Sil. Spr., Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>2-12-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville Montgomery Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i> | | | | ADDRESS
<i>Sil. Spr., Md.</i> | | 25a. REC'D BY REGISTRAR
<i>FEB 19 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

1998

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil within 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Item 22-410
3-11-69ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02655 | | 02650 | | | | | | | |
|--|--|---------|-------|---|--------|---|------|---|--|--|--|---|--|------------------------|--|--------|--|------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month Day Year | | 2b. HOUR
M | | | | | |
| Kenneth | | | Ray | | Miles | | | | | Feb 7 | | 1969 | | 6:55 P M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR
M | | | | | |
| M. | | W | | Feb 27, 1945 | | 23 YRS. | | | | | | Feb. 7 | | 6:45 P M | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | |
| | | | | U.S.A | | | | | | | | Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| Bethesda | | | | Suburban | | | | School Teacher | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | | Montgomery | | | | Rockville | | | | YES | | 884 College Parkway | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First | | Middle | | Last | |
| Kenneth | | | | S. | | Miles | | | | Helen | | | | Spring | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| NO | | | | | | | | Mrs. Jo Anne Miles | | | | 884 College Pkwy. | | | | Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Laceration of Brain -</u>
8160
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Fracture of Skull Mid-Posterior Fossa.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Trauma from Auto Accident.</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>Sudden.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR AM PM <u>6:45 P.M. Feb 7 1969</u> | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Car. he was driving on off highway.</u> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
<u>Highway 705</u> | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>705 at Camp Perserve Rd. Gaithersburg Montgomery Md.</u> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE <u>John G. Ball</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | 22b. DATE SIGNED
<u>Feb. 8, 1969</u> | | | | | | | |
| EXAMINER'S
NAME (Type)
<u>John G. Ball M.D.</u> | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE
<u>Feb. 10, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Hyattstown Meth. Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Hyattstown Frederick Md.</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>M. R. Etchison & Son, Frederick, Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>FFB 13 1969</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared Medical Examiner

MEDICAL CERTIFICATION

| 02656 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 02651 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | First
ROBERT | | | | | Middle
D. | | | | | Last
MILES | | | | | 2a. DATE OF DEATH
Month 2 Day 4 Year 69 | | | | | 2b. HOUR
10:55 PM | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
White | | | | | 5. DATE OF BIRTH
Dec. 4, 1907 | | | | | 6. AGE (In years
last birthday)
61 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) Vermont | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Holy Cross | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Designer Draftsman | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | | | | 13b. COUNTY Montgomery | | | | | 13c. CITY OR TOWN
Sil. Spring | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
13537 Georgia Avenue | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
Herbert Miles | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ernestine Rogers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | | | (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
077-05-4962 | | | | | 17. INFORMANT
Address
Muriel Miles 13537 Georgia Ave. Sil.Sp.Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Lymphosarcoma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? NO | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
James W. Egan MD | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
2/4/69 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) James W. Egan | | | | | | | | | | 22e. ADDRESS
5413 Cedar Lane - Bethesda | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | | | | | | | | 23b. DATE
2/8/69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home 1331 Rockville | | | | | | | | | | ADDRESS
Rockville, Maryland | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 7 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Judge | | | | | | | | | |

02332

02330

1. Name of the person
2. Date of birth
3. Place of birth
4. Sex
5. Race
6. Religion
7. Education
8. Occupation
9. Marital status
10. Date of marriage
11. Name of spouse
12. Date of death
13. Cause of death
14. Place of death
15. Burial place
16. Date of burial
17. Name of funeral home
18. Name of officiant
19. Name of witnesses
20. Name of officiant's parents
21. Name of witnesses' parents
22. Name of officiant's grandparents
23. Name of witnesses' grandparents
24. Name of officiant's great-grandparents
25. Name of witnesses' great-grandparents

02330-1965

1. Name of the person
2. Date of birth
3. Place of birth
4. Sex
5. Race
6. Religion
7. Education
8. Occupation
9. Marital status
10. Date of marriage
11. Name of spouse
12. Date of death
13. Cause of death
14. Place of death
15. Burial place
16. Date of burial
17. Name of funeral home
18. Name of officiant
19. Name of witnesses
20. Name of officiant's parents
21. Name of witnesses' parents
22. Name of officiant's grandparents
23. Name of witnesses' grandparents
24. Name of officiant's great-grandparents
25. Name of witnesses' great-grandparents

1. Name of the person
2. Date of birth
3. Place of birth
4. Sex
5. Race
6. Religion
7. Education
8. Occupation
9. Marital status
10. Date of marriage
11. Name of spouse
12. Date of death
13. Cause of death
14. Place of death
15. Burial place
16. Date of burial
17. Name of funeral home
18. Name of officiant
19. Name of witnesses
20. Name of officiant's parents
21. Name of witnesses' parents
22. Name of officiant's grandparents
23. Name of witnesses' grandparents
24. Name of officiant's great-grandparents
25. Name of witnesses' great-grandparents

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-58

| 02657 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 02652 | |
|--|--|---|---|--|---|--|---------------------------|
| 1. DECEASED-NAME
(Type or print) <i>Miller Lillian Pauline</i> | | | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>9</i> Year <i>69</i> | | 2b. HOUR
<i>4 P.M.</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
<i>April 26, 1888</i> | | 6. AGE (In years last birthday)
<i>80</i> YRS. | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
DAYS | HOURS |
| 7a. BIRTHPLACE (State or foreign country)
<i>Nebraska</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> | | Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Carroll Hall Sanitarium</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | 13b. COUNTY
<i>Montgomery</i> | 13c. CITY OR TOWN
<i>Sil. Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>Silver Spring, Md.
8505 Springvale Road</i> | | | |
| 14. FATHER'S NAME
First <i>Gustav</i> Middle <i>--</i> Last <i>Blixt</i> | | 15. MOTHER'S MAIDEN NAME
First <i>(Unknown)</i> Middle <i></i> Last <i></i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>--</i> | | 16b. SOCIAL SECURITY NO.
<i>Yes</i> | 17. INFORMANT
<i>Virginia P. Sassani</i> | | Address <i>Washington, D.C.
1212 Monroe St. N.E.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>
<i>485X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Bronchopneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 hrs</i>
<i>4 hrs</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Generalized atherosclerosis</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/5/68</i> , 19__, to <i>2/9/69</i> , 19__, that (I) (we) lost the deceased on <i>11/27/68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Patrick Jamison</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/9/69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Patrick Jamison, M.D.</i> | | | | 22e. ADDRESS
<i>11718 Georgia Silver Spring, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>2-12-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville Montgomery Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>C. Glen Carter</i> | | | | ADDRESS
<i>Sil. Spr. Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 17 1969</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i> | | | | | | | |

RECEIVED

JAN 10 1964

JAN 10 1964

JAN 10 1964

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JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CLERK WIFE MEDICAL EXAMINER 157 DOB-RAD

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
|---|--|------------------------------|--|--|--|---|--|---|--|--|--|--|--|----------|--|
| Rose | | | | | | | | Miller | | Month FEB Day 15 Year 69 | | 2 15 P. M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| FEMALE | | Caucasian | | Nov 1 1889 | | | | 80 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | | | |
| LATVIA | | U.S. | | WIDOWED | | DIVORCED | | Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | | | Holy Cross Hospital | | | | Housewife | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1008 N. Belgrade Rd | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Louis | | | | Bernstein | | | | Sarah | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | |
| Yes, no, or unknown | | | | | | Gerald Shutz 1008 Belgrade Rd. S.S. Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | | 1 DAY | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | YEARS | | | |
| (b) ARTERIOSCLEROTIC CORONARY ARTERY DISEASE | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-14, 1969, to 2-15, 1969, that (I) (we) last saw the deceased alive on 2-15, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| Bernard A. Heckman, M.D. | | | | FEB. 15, 1969 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | |
| BERNARD A. HECKMAN, M.D. | | | | 8107 Eastern Ave., Silver Spring, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | 2/17/69 | | P. O. W. Cemetery | | Waldheim Illinois | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| D. Nauspinsky | | | | 4321 N. SYMPHONY | | | | DATE FEB 19 1969 | | | | | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M - 1/35

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02659

02654

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) <i>Bessie</i> First Middle <i>Moon</i> Last | | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>28</i> Year <i>69</i> | | 2b. HOUR
<i>7:23 PM</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>7-9-83</i> | | 6. AGE (In years lost birthday)
<i>85</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery.</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Montgomery</i> | 13c. CITY OR TOWN
<i>Bethesda</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>6940 Winterberry Lane</i> |
| 14. FATHER'S NAME First Middle Last
<i>Charles T. Shimmman</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Lida - Scofield</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Eugene - Moon</i> Address <i>6940 Winterberry Lane</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial infarction-recent and remote with</i>
<i>4109</i> DUE TO, OR AS A CONSEQUENCE OF <i>aneurysmal dilatation of left ventricle</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>and rupture</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary arteriosclerosis with thrombosis</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> , to <i>2-28-69</i> , that (I) <i>two</i> last saw the deceased alive on <i>2-28-69</i> 19 <i>69</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>did</i> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Glenn D. Herman</i> M.D. | | 22c. DATE SIGNED
<i>2/28/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>John D Herman</i> | | 22e. ADDRESS
<i>Bethesda, Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>March 4, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft Lincoln Cemetery</i> | |
| 23d. LOCATION (City or Town) (County) (State)
<i>Colmar Manor Pro Geo Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>P. Gasch's Sons</i> | | ADDRESS
<i>Hyattsville, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 4 1969</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>James Judge</i> | |

03651

03650

you will find the same information in the
documentary history of the territory
and the
documentary history of the territory

PJ/1/2

1000 1000

1000 1000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02660

02655

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) <i>Elizabeth L. MOORE</i> | | | 2a. DATE OF DEATH
Month <i>Feb</i> Day <i>17</i> Year <i>1969</i> | | 2b. HOUR
<i>2:35</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>10-29-1892</i> | | 6. AGE (In years lost birthday)
<i>76</i> YRS. | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS
DAYS
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>IOWA</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i> | | 13b. COUNTY
<i>Montgomery</i> | 13c. CITY OR TOWN
<i>Rockville</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
<i>11710 Rockwing Haver Rd</i> |
| 14. FATHER'S NAME First Middle Last
<i>Harvey</i> <i>Mo</i> <i>Lovett</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>ESSA</i> <i>HARRIS</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>XXXX</i> (If yes give year or dates of service) <i>XXXX</i> | |
| 16b. SOCIAL SECURITY NO.
<i>579-40-7594</i> | | 17. INFORMANT Address # <i>13</i>
<i>MR. Donald Moore-husband-same item</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bronchopneumonitis</i>
<i>4369</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Recurrent C.V. AC left hemiplegia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Polycephthemia Vera</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>4 months</i>
<i>undeter.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>generalized atherosclerosis and A.S.H.D. compensated.</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/8/1969</i> to <i>2/17/1969</i> , that (I) (we) last saw the deceased alive on <i>2/17/1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Faruk Ozer</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/17/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>FARUK OZER</i> | | 22e. ADDRESS
<i>1125 Rockville Pike Rockville, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>2/19/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Cemetery</i> | |
| 23d. LOCATION (City or Town) (County) (State)
<i>Rockville, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland</i> | | 25a. REGISTERED
<i>FEB 20 1969</i> DATE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 12
45M - 116

03332

03332

OFFICE OF THE

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, Texas.

-Inhabitant-Name List

500-10-1994

1994

1994

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, Texas.

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, Texas.

Rockville, Maryland
FEB 29 1994

Rockville, Maryland
FEB 29 1994
Rockville, Maryland
FEB 29 1994
Rockville, Maryland
FEB 29 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|--|--|---|---|
| 02661 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 02656 | |
| Item 6 Film 410 3/7/69 kk | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME (Type or print) <i>MARY F MORRIS</i> | | | 2a. DATE OF DEATH Month <i>February</i> Day <i>28</i> Year <i>1969</i> | | 2b. HOUR <i>6:10p^M</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH <i>4/9/01</i> | | 6. AGE (In years lost birthday) <i>67</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HCAH</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montg.</i> | 13c. CITY OR TOWN <i>Rockville</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <i>9105 Scott Drive</i> |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address <i>Hospital Records</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Bronchopneumonia</i>
<i>485X</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>① Pyelonephritis & thrombosis ③ Diabetes mellitus</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/5/69</i> , to <i>2/28/69</i> , that (I) (we) last saw the deceased alive on <i>2/28/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>H. C. MAGANZINI</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>2/29/69</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>H. C. MAGANZINI</i> | | 22e. ADDRESS <i>50 W. Edmonston Dr., Rockville, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>3/4/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Michaels Cemetery</i> | |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Rockville, Md</i> | | 23d. LOCATION (City or Town) <i>Long Island</i> (County) <i>N.Y.</i> (State) | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <i>MAR 4 1969</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 155-4
45M - 11-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02662

02657

| | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Thomas GEORGE MULLICAN | | | 2a. DATE OF DEATH
2 Month 20 Day 69 ear | | | 2b. HOUR
10 P M | | | | |
| 3. SEX
MALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
8-15-85 | | 6. AGE (In years last birthday)
83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SAN. & Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
General Maintenance, Armory | | | 12b. KIND OF BUSINESS OR INDUSTRY
Sil. Spr. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
SILVERSPRING | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
10708 Lorain Ave. | | | 14. FATHER'S NAME First Middle Last
GEORGE MULLICAN | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Kemp | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
220-12-3171 | | | 17. INFORMANT Harvey Lindsay- Address same 13c
HOSPITAL RECORDS - Sil Spg. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Embolic & suppurative pneumonia
444.2
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) with metastatic thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchopneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19, 1967 , to Jan 20, 1967 , that (I) (we) last saw the deceased alive on Jan 20, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Boris Rabin DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED Jan 21, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) BORIS RABKIN | | | | | | 22e. ADDRESS 1019 University Blvd, Ex | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
February 25, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Colesville, Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Colesville, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | | | 25a. REC'D BY REGISTRAR
FEB 26 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

72320

THE

UNITED STATES OF AMERICA

05880



72320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Vinson Montgomery Mullican | | | | | | 2a. DATE OF DEATH
Feb. Month 28 Day 68 Year 69 | | | 2b. HOUR
1:05a | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
3-12-78 | | | 6. AGE (In years last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Rt. 1 Box 59830 | | | |
| 14. FATHER'S NAME First Middle Last
John Mullican | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
218-24-9845 | | 17. INFORMANT
Hospital Records | | | | Address
Olney, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, Chronic
4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) A.H.D.
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterio-Atherosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years
Years
Years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus, Senility. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1950 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on Feb. 27 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Jack Schumacher DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
2-28-69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. J. Schumacher | | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
3-3-69 | | 23c. NAME OF CEMETERY OR CREMATORY
St Rose. | | 23d. LOCATION (City or Town) (County) (State)
Gaithersburg Monte Md | | | | | | |
| 24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS Gaithersburg, Md | | | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |
| DATE MAR 3 1969 | | | | | | | | | | | | |

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• 1000

DECEMBER 30, 1971 1.28

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• 15

02664

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--------|---|-------------------------------------|---|-------------|---|--------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR AM | | |
| Oscar | | Lee | | Mullins | February 15 1969 | | 3:30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | White | | 27 February 1931 | | 37 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Tennessee | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Bethesda | | The Clinical Center, NIH | | Accountant | | Printing Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Tennessee | | V | | Harriman | | | | P.O. Box 376 | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Oscar | | B. | | Mullins | Gladys | | | | Morgan |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| Yes | | 411-40-6629 | | Bethesda, Maryland 20814
The Medical Records, The Clinical Center, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary infarction, right lower lobe</u>
<u>3960</u>
DUE TO, OR AS A CONSEQUENCE OF <u>tricuspid stenosis & tricuspid insufficiency</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease, mitral, aortic and/</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that this (this hospital) attended the deceased from <u>26 January, 1969</u> , to <u>15 Feb., 1969</u> , that it (we) last saw the deceased alive on <u>15 February 1969</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above it (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Robert Mason MD</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>15 February 1969</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Robert J. Mason, M.D.</u> | | | | | | 22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u> | | | |
| 23a. BURIAL, CREMATION,
or other disposition | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial-Transit | | 2/16/1969 | | Rosedale Memorial Gardens | | Harriman, Tenn. | | | |
| 24. FUNERAL DIRECTOR
<u>1331 Rockville Pike</u>
<u>Tyson Wheeler Funeral Home Rockville, Md</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 19 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William J. Judge</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 409 2/24/69k 02665 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02660

| | | | | | | | | | | | | | | |
|---|---------|------------------------------|--|--|------------------------------------|---|------|------------------------------|---|-----------|----------|--|---------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | |
| ANNA P. MURTAUGH | | | | | | Month Day Year | | | | 2 17 1969 | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | |
| F | C | 10-28-79 | 89 88 YRS | MONTHS | DAYS | HOURS | MIN. | Month Day Year | | | | 4:20 A.M. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | |
| New Jersey | | U.S.A. | | | | Montgomery | | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Kensington, Md. | | | Kensington Gardens | | | housewife | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| STATE Maryland | | | Montgomery | | | Kensington | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 10912 Clermont Ave. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John Alexander Stuart | | | Matilda Girth | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| No | | | 138-14-4551 | | | Joseph S. Murtaugh | | | 10912 Clermont Ave. Kensington, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Acute | | | | | | | | | | | | 24 hours | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease | | | | | | | | | | | | Years | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Generalized | | | | | | | | | | | | Years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| Fracture of the Hip | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| CAUSE OF DEATH | | | P.M. Jan 19/69 | | | Fell at home | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | | State | |
| AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> | | | Home | | | 10912 Clermont Ave. | | | Kensington | | Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | John G. Ball | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | John G. Ball | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | Feb-17-1969 | | |
| | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | |
| | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) | | (State) | |
| Burial | | | 2-20-69 | | St. Mary's Cemetery | | | Westfield Hampden | | | Mass. | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Robert A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md. | | | FEB 19 1969 | | | Charles Judge | | | | | | | | |

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STATE OF
NEW YORK

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) WALTER ALEXANDER NEIL | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year
FEB 18 1969 | | | 2b. HOUR
8:15 P.M. | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
4-23-1893 | | | 6. AGE (In years lost birthday)
75 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
NEW YORK | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SANITARIUM + HOSP. CHIROPRACTOR | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CHIROPRACTOR | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
WASHINGTON | | | 13c. CITY OR TOWN
WASHINGTON | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
1401 LONGFELLOW ST. N.W. | | | 14. FATHER'S NAME
First Middle Last
ALEXANDER NEIL | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
LOUISA OAKSFORD | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
577-03-2318 | | | 17. INFORMANT
Marion Miller | | | Address
W.S.H., Takoma Park, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
1541
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) INTESTINAL OBSTRUCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA OF RECTUM | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
3 WEEKS
UNKNOWN (1 YR?) | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
INFECTION OF ABDOMINAL WALL | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1-31-69 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
BOWEL OBSTRUCTION | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31 , 1969, to 2-18 , 1969, that (I) (we) lost the deceased alive on 2-18 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dwight R. Smith | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
2-18-69 | | |
| 22d. PHYSICIAN'S NAME (Type)
DWIGHT R. SMITH | | | | | | 22e. ADDRESS
800 PERSHING DRIVE S.S. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | | 23b. DATE
2/21/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges, County, Md. | | |
| 24. FUNERAL DIRECTOR
The H.H. Hines Co. | | | | | | ADDRESS
2901 14th St. N.W. | | | 25a. RECEIVED BY REGISTRAR
FEB 21 1969 | | |
| | | | | | | DATE | | | 25b. REGISTRAR'S SIGNATURE | | |

13330

13330

CONFIDENTIAL

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02667

CERTIFICATE OF DEATH

02662

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print)
First <i>Mary</i> Middle <i>Grace</i> Last <i>Nolte</i> | | | 2a. DATE OF DEATH
Month <i>Feb.</i> Day <i>24</i> Year <i>1969</i> | | | 2b. HOUR
<i>5:50A</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Oct. 31, 1871</i> | | 6. AGE (In years last birthday)
<i>97</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Penna.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Jakoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Park Haven Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Sil. Spr.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>1309 Dale Drive</i> | | 14. FATHER'S NAME
First <i>Reverend John Thrush</i> Middle <i></i> Last <i></i> | | 15. MOTHER'S MAIDEN NAME
First <i>Rachael</i> Middle <i>--</i> Last <i>Mann</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service) <i>--</i> | | 16b. SOCIAL SECURITY NO.
<i>579-60-2103</i> | | 17. INFORMANT
Address <i>Walter J. Nolte 1309 Dale Drive, Sil. Spr., Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerosis, generalized, severe 17 yrs.</i>
<i>4409</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>None</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 3</i> , 19 <i>51</i> , to <i>Feb. 24</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb. 23</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>George Dewey M.D.</i> | | 22c. PHYSICIAN'S NAME (Type)
<i>George Dewey, M.D.</i> | | 22d. ADDRESS
<i>2540 Mass. Ave., N.W., Wash., D.C. 20008</i> | | 22e. DATE SIGNED
<i>Feb. 24, 1969</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>2-27-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Methodist Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Lewistown, Pa.</i> | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | 24a. ADDRESS
<i>8434 Georgia Avenue</i> | | 24b. REC'D BY REGISTRAR
DATE <i>Feb 28 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

23024

RECEIVED

23024

TO THE HONORABLE SECRETARY OF THE ARMY
WASHINGTON, D. C.
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|--|--|--|------------------|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| LEONARD E. NORTON | | | | | | Feb. 17, 1969 | | | 8:03 A.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | Cauc. | | Jan. 16, 1929 | | | 40 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Mass. | | | U. S. | | | | | | Montgomery | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Rockville | | | 13420 Bartlett Street | | | None | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | | Rockville | | | YES | | | 13420 Bartlett Street | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| Roland Norton | | | Marion G. MacGray | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| No | | | None | | | Mother | | | Same as Item 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Uremia</u> | | | | | | | | | | 9 days | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | 34 years | | | | |
| (b) <u>Epilepsy</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 11, 1967</u> , to <u>Feb. 17, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 8, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | |
| <u>J. C. K. Yu</u> | | | Feb. 17, 1969 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | |
| J. C. K. Yu | | | 4912 Adrian Street | | | | | | | | | | | |
| | | | Rockville, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 2-19-69 | | | Puritan Lawn Cemetery | | | West Peabody, Mass. | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. FILED BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | FEB 19 1969 | | | <u>[Signature]</u> | | | | | |

1980

STATE OF TEXAS

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1980-01-01
COUNTY OF DALLAS, TEXAS

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02669

CERTIFICATE OF DEATH

02664

| | | | | | | | | |
|---|--|--|--|---|--|---|--|--|
| 1. DECEASED-NAME (Type or print)
Mary Louise Nutter | | | 2a. DATE OF DEATH
Feb. ^{Month} 6 ^{Day} 1969 ^{Year} | | | 2b. HOUR ^p
11:40M | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
8/19/24 | | 6. AGE (In years last birthday)
44 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Assembler | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spng | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
14704 Good Hope Road | | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrical | | | | | |
| 14. FATHER'S NAME First Middle Lost
Henry Boston | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
Effie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
no | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Records Address
Montgomery General Hospital, Olney, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CACHEXIA
174X DUE TO, OR AS A CONSEQUENCE OF METASTASIS - GENERALIZED
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA BREAST
DUE TO, OR AS A CONSEQUENCE OF (c) 14 MONTHS | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WEEKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
ADENOCARCINOMA UTERUS | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER, 1967 , to 6 FEB, 1969 , that (I) (we) last saw the deceased alive on 6 FEB 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Donald R. Lewis MD | | | | DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
7 FEB 69 | | |
| 22d. PHYSICIAN'S NAME (Type)
Donald R. Lewis, M.D. | | | | 22e. ADDRESS
700 Cloverly st., Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
2-10-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Good Hope Cem. | | 23d. LOCATION (City or Town) (County) (State)
Colesville Monty Md | | |
| 24. FUNERAL DIRECTOR
Robert L. Snowden Rockville Md | | | | 25a. REC'D BY REGISTRAR
FEB 13 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02670

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02665

| | | | | | | | | | |
|--|-------------------------|--|---|---|--|---|---|--|------------------------|
| 1. DECEASED-NAME
(Type or Print) <i>Richard J O'Brien</i> | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <i>Feb 1</i> 19 <i>69</i> | | | | 2b. HOUR <i>1:15</i> M | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>10/18/1908</i> | 6. AGE (In years last birthday)
<i>60</i> YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month <i>Feb</i> Day <i>1</i> Year <i>1969</i> | | | 2d. HOUR <i>1:15</i> M |
| 7a. BIRTHPLACE (State or foreign country)
<i>PENN.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Cherry Chase</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>REPORTER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>NEWSPAPER</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i> | | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN
<i>Cherry Chase</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>7017 Bywood La</i> | | |
| 14. FATHER'S NAME
<i>JOHN O'BRIEN</i> | | | 15. MOTHER'S MAIDEN NAME
<i>UNKNOWN</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>TERESA L.O'BRIEN</i> | | ADDRESS
<i>13 E</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction -</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Coronary occlusion -</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arterio-Sclerosis -</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 days</i>
<i>4 days</i>
<i>years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John E. Bell</i>
EXAMINER'S NAME (Type) | | | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<i>Feb 1, 1969</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>2/4/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>CALVARY CEM.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>FAIRFAX VA.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>HANLON FUNERAL HOME - WASH. D.C.</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 7 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02671

02666

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) MARGARET M. OGIE | | | 2a. DATE OF DEATH
Feb. 27 Day Year 69 | | 2b. HOUR
5:25 PM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
11-30-1893 | | 6. AGE (In years last birthday)
75 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
IRELAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | 13b. COUNTY
PRINCE GEORGE | 13c. CITY OR TOWN
BELTSVILLE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
4809 OLYMPIA AVE | |
| 14. FATHER'S NAME
First Middle Last
DENNIS LEAHY | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARY DUNN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
577 34 2093 | 17. INFORMANT
Address
William Ogie - Son - SAME | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage
4124 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Unknown | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Myocardial ischemia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 1962 , 19____, to 2/26 , 19 69 , that (I) (we) last saw the deceased alive on 2/26 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Madoff | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/27/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE
March 3, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | |
| 23d. LOCATION (City or Town) (County) (State)
Silver Spring Montgomery Md. | | | | | |
| 24. FUNERAL DIRECTOR
Arthur Walters | | ADDRESS
2254 Cornell St NW | | 25a. RECEIVED BY REGISTRAR
DATE
FEB 28 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
William J. Jones | |

3867

STATE OF DEATH

3868

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Date of Birth", "Cause of Death", "Place of Death", "Time of Death", "Signature", and "Date" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|---|---|---|--|------------------|---------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 02672 | | | | | 02667 | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| GERALD EVERETT OLIVER | | | | | 2 Month 4 Day 69 Year | | | 3 ²⁵ P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | |
| MALE | | CAUC. | | 12/27 /03 | | 65 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MASS. | | USA | | | | MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TAKOMA PARK | | | WASHINGTON SAN. + HOSP. | | | P.O. Dept. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| MARYLAND | | | MONTGOMERY | | | TAKOMA PARK | | 8012 MAPLE AVE. | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| CHARLES OLIVER | | | ADA BOUTWELL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| | | | N | | HOSPITAL RECORDS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of tail of pancreas | | | | | | | | | | |
| 1578 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) Rupture of left splenic artery with 16 hr | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) massive retroperitoneal hemorrhage | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 1936, to Feb 4, 1969, that (I) (we) last saw the deceased alive on Feb 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Philip E. Jones M.D. | | | | | | | | | 2-4-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| Philip E. Jones, M.D. | | | | | 800 Reisterstown Drive Silver Spring, Md 20910 | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | Feb. 9, 1969 | | Forest Hill Cemetery | | Fitchburg | | | | Mass. |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25. FILED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Arthur Walters, 254 Carroll Pl NW. DC | | | | | FEB 11 1969 | | | | | |

02007

OFFICE OF DEAN

02007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 02673 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 02668 | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Linden P. Oliver | | | | 2a. DATE OF DEATH Month Day Year
2 25 69 | | 2b. HOUR
12 1/2 P.M. | |
| 3. SEX
7 | | 4. RACE
W | | 5. DATE OF BIRTH
3/14/1900 | | 6. AGE (In years last birthday)
68 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Potomac Valley Nsg. Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Public stenographer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
3 Pookes Hill Rd. | | 14. FATHER'S NAME First Middle Last
Allen S. Pattison | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ora Hoffman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No | | 16b. SOCIAL SECURITY NO.
577-07-5470 | | 17. INFORMANT
William H. Pattison | | | |
| | | | | 7242 Wilsons Ave. Bethesda, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cachexia
1621 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
about 8 mo | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 1969, to Jan 24, 1969, that (I) (we) last saw the deceased alive on Jan 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Allen J. O'Neill M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/25/69 | |
| 22d. PHYSICIAN'S NAME (Type)
Allen J. O'Neill M.D. | | | | 22e. ADDRESS
8601 Old Georgetown Rd | | | |
| 23a. BURIAL, CREMATION, or other disposition (Type)
Cremation | | 23b. DATE
2/25/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Md. | |
| 24. FUNERAL DIRECTOR
Lyon Wheeler | | | | 1331 Rockville Pike
Rockville, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 28 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---------|--|------------------|--|--|---------------------------------|--|--|--|------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| JOHN | | | NMN OROIAN | | | February 24 1969 | | | 2:55A | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| MALE | | WHITE | | May 17, 1895 | | | 73 YRS. | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| Romania | | | American | | | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Takoma Park | | | Washington San. & Hospital | | | Gov't Worker | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | | Burtonsville | | | | | | 14601 Old Columbia Pike | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John | | | Oroian | | | Florence | | | UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | |
| none | | | 213-42-8515-M | | | Hospital Record & Son, JOHN E. OROIAN | | | | | | Address 2211 FAIRLAND RD. S.S. MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Thromboses | | | | | | | | | | | | | | |
| 4123 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| Chronic Bronchitis | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1965, to Feb 24, 1969, that (I) (we) last saw the deceased alive on Feb 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | 22f. ADDRESS | | |
| Joseph Smith, M.D. | | | Feb 24 1969 | | | JOSEPH SMITH, M.D. | | | 4140 Sandy Springs Rd. Burtonsville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | FEB 26, 1969 | | | FORT LINCOLN CEMETERY | | | COLMAR MANOR MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| W.W. CHAMBERS Co. RIVERDALE, MD | | | FEB 26 1969 | | | J. Charles Judge | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02675 CERTIFICATE OF DEATH 02670

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVY CHASE MD. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVY CHASE, MD. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8516 Aragon Lane | | | | d. STREET ADDRESS
8516 Aragon Lane | | | |
| 3. NAME OF DECEASED (Type or print)
First Amelia Middle Orphanos Last Orphanos | | | | 4. DATE OF DEATH
Month February Day 6 Year 1969 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
UNKNOWN | 9. AGE (in years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | | 11. BIRTHPLACE (County & State, or foreign country)
Greece | | 12. CITIZEN OF WHAT COUNTRY
U.S. |
| 13. FATHER'S NAME
DEMETRIUS KORAKIS | | | | 14. MOTHER'S MAIDEN NAME
EVANGELINE (UNKNOWN) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
Constance Beahn Address 2 a, b, c, d above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
4123 DUE TO (b) Myocardial Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Arteriosclerotic Heart Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
1 wk
over 5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Generalized and Cerebral Arteriosclerosis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 48 , to Feb 6 , 19 69 , that (I) (we) last saw the deceased alive on Feb 6 , 19 69 , and that death occurred at 10:30 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Louis H. Shuman | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. Feb 6, 1969 | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
LOUIS H. SHUMAN | | | | 22d. ADDRESS
1635 Mass. Ave. N.W. Wash. D.C. 20036 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
10 FEB. 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City, town or county) (State)
BLADENSBURG MD. | |
| 24. FUNERAL DIRECTOR
PINARDI FUNERAL HOME, Inc. | | | | ADDRESS
7400 GEORGETTA AVE., N.W., WASHINGTON, DC 20012 | | 25a. REC'D BY REGISTRAR
FEB 11 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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VOGEL, E. J., and J. L. HARRIS. 1970. The

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

| MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---------|--|------------------|--|---|--|-----------------|---|-----------------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| RAMON / ROMAN | | | O. | | | OVANDO | | | 9:04A | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | 8/9/85 | | 83 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7d. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Mexico | | | U.S.A. | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross Hospital | | | Butler - retired | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Montgomery | | | Sil. Sprg. | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 17. INFORMANT | | |
| John | | | Ovando | | | Solidad | | | Osio | | |
| 16b. SOCIAL SECURITY NO. | | | 17. ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 129-26-2494 | | | Alice M. Ovando | | | Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | PART I. DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) | | | | | |
| 4123 | | | DUE TO, OR AS A CONSEQUENCE OF | | | (b) | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | DUE TO, OR AS A CONSEQUENCE OF | | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b. DATE SIGNED | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | |
| Belden R. Reap | | | Feb. 20, 1969 | | | Burial | | | 2-24-69 | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | |
| Gate of Heaven | | | Silver Spring, Md. | | | Francis J. Collins | | | FEB 24 1969 | | |
| 25b. REGISTRAR'S SIGNATURE | | | 26. REGISTRAR'S SIGNATURE | | | 27. REGISTRAR'S SIGNATURE | | | 28. REGISTRAR'S SIGNATURE | | |
| Belden R. Reap | | | Belden R. Reap | | | Belden R. Reap | | | Belden R. Reap | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|---|-------------------------|---|--|---|-------------------------------|--|--|---|
| 1. DECEASED-NAME
(Type or Print) WHITTIE C OWENS | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year FEB 24 1969 | | | 2b. HOUR OF ESTI-
DEATH MATED 8:45 AM | | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
4/9/90 | 6. AGE (In years last birthday)
78 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year FEB 24 1969 | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11809 TIMBER LANE |
| 14. FATHER'S NAME First Middle Last
JAMES W. THOMPSON | | | 15. MOTHER'S MAIDEN NAME First Middle Last
GEORGIANA YEAREXXXXX HERBERT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT ADDRESS
RUTH BOCKHAUS - DAUGHTER - SAME | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4124 Coronary Insufficiency Acute
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Vascular Disease -
DUE TO, OR AS A CONSEQUENCE OF
(c) years. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED FEB 24, 1969 | | |
| EXAMINER'S NAME (Type) JOHN G. BALL M. D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
FEB. 27, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BUSHWOOD, ST. MARY'S, MARYLAND | | |
| 24. FUNERAL DIRECTOR
W. CLARKE | | | | ADDRESS
MATTINGLEY LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] |

5380

• **EDMAN**

INSTRUMENT APPROX.

;

YOUTHERN YOUTH OFSAD 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621

DATE _____

THURSDAY, NOVEMBER 11, 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
|---|--|------------------------------|--|---|------------------------------------|---|-------------------|---|-----------------------------------|--|------|
| Mary Frances | | | | | | Pace | 2 | Month 13 | Day 69 | Year 2400M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | 12/29/1894 | | 74 YRS. | | MONTHS | DAYS | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Canada | | U.S.A. Naturalized | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Wheaton | | | Randolph Hills Nursing Home | | | Housewife | | | At Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | Montgomery | | S.S. | | YES | | 3350 Cheswick Court | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Joseph Fairbairn | | | | | | Jean Marshall | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | 368-30-9112 | | | W.F. PACE, SAME AS #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Irreversible Brain Damage | | | | | | | | | | 1 yr. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) multiple CVA's | | | | | | | | | | 3 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Cerebral Arteriosclerosis | | | | | | | | | | 4 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 1966, to 2/13, 1969, that (I) (we) lost the deceased alive on 2/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE R.T. Benack MD DEGREE | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 2/13/69 | |
| 22d. PHYSICIAN'S NAME (Type) R.T. Benack MD | | | | | | 22e. ADDRESS 4115 Colic Drive, Wheaton | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| CREMATION | | | 2/17/69 | | CEDAR HILL CREM. | | | SUITLAND, MD. | | | |
| 24. FUNERAL DIRECTOR Jos. GAWLER'S SONS, 5130 WIS. AVE, NW, WASH., D.C. | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | DATE FEB 19 1969 | | | | | |

27350

27350

WILSON

100-104-1114

100-104-1114

02679

CERTIFICATE OF DEATH

02674

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|--------------|
| 1. DECEASED-NAME
(Type or print) <u>LILLIE MARY PATRICK</u> | | | 2a. DATE OF DEATH
2 Month 20 Day 69 Year | | | 2b. HOUR
9:40 P.M. | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>CAUCASIAN</u> | | 5. DATE OF BIRTH
<u>3-28-1899</u> | | 6. AGE (In years
last birthday)
<u>89</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
<u>WASH. D.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery Co.</u> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Chevy Chase</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <u>Bethesda-Silver
Spring Nursing Home</u> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<u>DET. - CLERK</u> | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<u>RET'S ADMIN</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <u>D.C.</u> | | | 13b. COUNTY
<u>—</u> | | 13c. CITY OR TOWN
<u>WASHINGTON</u> | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
<u>6232-32nd St. N.W.</u> | |
| 14. FATHER'S NAME First Middle Last
<u>GEORGE — MILLER</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>JULIA McELROY — McELROY</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <u>NO</u> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<u>579-60-1611</u> | | 17. INFORMANT Address
<u>PERCY PATRICK - 6236 UTAH AVE, NW WASH. D.C.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
<u>4339</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Cerebral Artery Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral Arterio-sclerosis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>5 days</u>
<u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 12</u> , 19 <u>67</u> , to <u>Feb 20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert B. Harell MD</u> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>Feb. 20, 1969</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Robert B. Harell MD</u> | | | | | | 22e. ADDRESS
<u>5516 Nebraska Ave - D.C.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | 23b. DATE
<u>2/24/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cem.</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>WASHINGTON, D.C.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Jos. GAWLER'S SONS, 5130 WIS. AVE, N.W., WASHINGTON, D.C.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 26 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Richard Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|-------------------------------------|---|-----------------------------|--|
| 02680 | | | | | | CERTIFICATE OF DEATH | | | 02675 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Francis Xavier Payne | | | | | | 2a. DATE OF DEATH Month Day Year
2-21-69 | | | 2b. HOUR A.M. P.M.
3:50 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
11-19-22 | | | 6. AGE (In years last birthday) YRS.
46 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
America | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Sanitarium | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Attorney-Salesmanager | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
10705 Georgia Avenue | | |
| 14. FATHER'S NAME First Middle Last
Arthur Payne | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret Elbert | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes | | | | 16b. SOCIAL SECURITY NO.
WW2-Air Force 577-26-4034 | | 17. INFORMANT Address
Patient's chart | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1620 Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple small lung abscesses
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma trachea
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
day
week
5 mos | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Kenneth Cruze DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 2/21/69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) KENNETH CRUZE | | | | | | 22e. ADDRESS 831 UNIV. BLVD. EAST SIL. SP. MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 2-24-69 | | 23c. NAME OF CEMETERY OR CREMATORY Gate - 7 - Heaven Cem. | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR Francis Collins 500 University Blvd. Silver Spring, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 24 1969 | | 25b. REGISTRAR'S SIGNATURE Richard Judge | | | | |

02359

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-105. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> 02681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02676 </div> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>Ernest</i> | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> <i>Feb. 3</i> 1969 | | | 2b. HOUR <i>12 P.M.</i> | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>W.</i> | | 5. DATE OF BIRTH <i>Feb 15 1897</i> | | 6. AGE (In years) <i>71</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD <i>Feb 8</i> Year <i>1969</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Germany</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i> | | | 12a. USUAL OCCUPATION (and of work done during most of working life, even if retired.) <i>Salesman</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i> | | | 13b. COUNTY <i>Montgomery</i> | | | 13c. CITY OR TOWN <i>Bethesda</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME <i>David</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME <i>Sara Seelig</i> | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>578-16-9717-A</i> | | | 17. INFORMANT <i>Vera Petzal</i> | | | ADDRESS <i>SAME - 13e</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4124 Coronary Insufficiency Acute</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cardio-Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden.</i>

<i>Years.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Feb. 9, 1969</i> | | |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>2/11/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>MT. LEBANON Cem.</i> | | 23d. LOCATION (City or Town) <i>Hyattsville, Md.</i> | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR <i>BERNARD DANZANSKY</i> ADDRESS <i>3001-14th St. N.W. Wash. D.C.</i> | | | | | | 25a. REC'D BY REGISTRAR <i>FEB 13 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>William Judge</i> | | | |

03330

MINERAL EXPLORATION, DEPARTMENT OF MINES

18890

FOR SALE
RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|-----------------------------------|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 02682 | | | | | | | | | | | | |
| 02677 | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>Ralph A Ponte</u> | | | | | | 2a. DATE OF DEATH <u>2</u> Month <u>5</u> Day <u>69</u> Year | | | 2b. HOUR <u>5:45</u> M | | | |
| 3. SEX <u>M</u> | | 4. RACE <u>W</u> | | 5. DATE OF BIRTH <u>10/7/01</u> | | | 6. AGE (In years last birthday) <u>67</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Silver Spring</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>RESTAURANTIER</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if admission) STATE <u>Del.</u> | | | 13b. COUNTY <u>Wilmington</u> | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>2305 Hillside Rd.</u> | | | | |
| 14. FATHER'S NAME First <u>VINCENT</u> Middle <u>PONTE</u> Last | | | | 15. MOTHER'S MAIDEN NAME First <u>MARIA</u> Middle <u>CHIARELLI</u> Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <u>165-10-2535</u> | | 17. INFORMANT <u>Mrs. Ponte</u> Address <u>139, c, d, e above</u> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u>
<u>6822</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Gram negative sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pseudomonas sp. abscess, right axilla</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>23 Jan</u> , 19 <u>69</u> , to <u>5 Feb</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5 Feb</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Judith Band</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>2-5-69</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>J. Fredrick BARR, MD</u> | | | | 22e. ADDRESS <u>4500 College Ave, College Park, MD</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>8 Feb 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) <u>CLAYMONT DELAWARE</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME INC.</u> | | | | ADDRESS <u>7400 GEORGETOWN AVE, N. W. WASHINGTON, DC 20012</u> | | 25a. REC'D BY REGISTRAR <u>FEB 10 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | |

1.230

INSTRUCTIONS TO THE PUBLIC

93880

Handwritten notes and markings on the right margin, including a large 'C' and various illegible scribbles.

A large rectangular area containing faint, illegible text and markings, possibly representing a form or document content.



02678

02683

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Eugene LeRoy Powell Jr. | | | 2a. DATE OF DEATH
Month February Day 7 Year 1969 | | | 2b. HOUR A 12:01M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
9 May 1904 | | 6. AGE (In years last birthday)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
South Carolina | | 13b. COUNTY
Latta | | 13c. CITY OR TOWN
Latta | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
301 West Main Street | |
| 14. FATHER'S NAME First Middle Last
Eugene LeRoy Powell Sr. | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Estelle Bethea | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
NOT AVAILABLE | | 17. INFORMANT The Medical Record Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive upper GI hemorrhage
2050
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute myelocytic leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 Hours
26 / 8 Months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 Jan. , 19 69 , to 7 Feb. , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 February 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Brian W. Goodell, M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
7 February 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Brian W. Goodell, M. D. | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
2/10/1969 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
DILLON, SOUTH (SC. CAR.) | | | |
| 24. FUNERAL DIRECTOR
William M. Hyson | | | | ADDRESS
Wash., D.C. | | 25a. REC'D BY REGISTRAR
DATE FEB 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|------------------------------|--|---|---|---|--|--|--------|-----------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| J. Orin | | -- | | Powers | Feb. 1969 | | 9:30 PM | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| Male | White | | June 19, 1890 | | 78 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Illinois | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | | Colonial Villa Nursing Home | | Professor | | College | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| Md. | | Montgomery | | Sil. Spr. | | 13e. STREET AND NUMBER | | | | |
| | | | | | | 13700 Carlisle Court | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| John | | -- | | Powers | Nancy | | J. | | Irwin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| No | | 578-32-9377 | | John Powers | | 13700 Carlisle Court, S.S., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident (CVA)</u>
4369 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-3 days
3-4 years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1965, to 2-16, 1969, that (1) (we) last saw the deceased alive on 2-15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Morris Perry, M.D. | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-17-69 | |
| 22d. PHYSICIAN'S NAME (Type)
Morris Perry, M.D. | | | | | 22e. ADDRESS
11602 Georgia Avenue, Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 2-18-1969 | | Rock Creek Cemetery | | Washington, D. C. | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | ADDRESS
Sil. Spr., Md. | | 25a. RECEIVED BY REGISTRAR
FEB 20 1969 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 10-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Sarah E Prather | | 2a. DATE OF DEATH
2 Month 3 Day 69 Year | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
8/24/91 | |
| 6. AGE (In years
lost birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Montgomery | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Holy Cross | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | |
| 12b. KIND OF BUSINESS OR
INDUSTRY | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | 13b. CITY OR TOWN
Gaithersburg | |
| 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET AND NUMBER
8601 Warfield Rd | | | |
| 14. FATHER'S NAME First Middle Last
THOMAS COPELAND | | 15. MOTHER'S MAIDEN NAME First Middle Last
SARAH SANE WHITE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Celestine McBRON - Rockville, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4369 stroke - sepsis
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Calcified Arterio Sclerosis | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
9 days
Years 10+
Years > 2 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 69 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from June 19 68, to February 5, 19 69, that (I) (we) last
saw the deceased alive on February 1, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Hugo G. Graziani, MD. DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> 22c. DATE SIGNED
2/3/69 | |
| 22d. PHYSICIAN'S
NAME (Type) HUGO G. GRAZIANI | | 22e. ADDRESS
10101 GEORGIA AVENUE S.S., MD. | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) BURIAL | | 23b. DATE
2-28-69 | | 23c. NAME OF CEMETERY OR CREMATORY
BROOKE GROVE CEM. LAYTONVILLE, MONTS. MD | |
| 23d. LOCATION (City or Town) (County) (State) | | 24. FUNERAL DIRECTOR
George R. Snowden Rockville | | 25a. REC'D BY REGISTRAR
DATE FEB 11 1969 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

03884

RECORDS OF THE

03884

1911

1911

Montgomery

X

1911

Montgomery

Silver Spring

1911

Montgomery

Continued

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~burial~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02688

02681

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Rachel A Pratt</i> | | 2a. DATE OF DEATH
Month <i>2</i> Day <i>3</i> Year <i>69</i> | | 2b. HOUR
<i>7:45</i> AM | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>NEGRO</i> | | 5. DATE OF BIRTH
<i>1901</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
<i>Montgomery</i> | | 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Holy Cross Hosp.</i> | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13a. STREET AND NUMBER
<i>4011 1/2 Pipers Mill Rd.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>KENSINGTON</i> | |
| 14. FATHER'S NAME
First <i>Robert</i> Middle <i>Addison</i> Last <i>AMANDA</i> | | 15. MOTHER'S MAIDEN NAME
First <i>AMANDA</i> Middle <i>?</i> Last <i>?</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes, give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary embolization</i>
<i>4122</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Acute pulmonary edema</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Hypertensive cardiovascular disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Lawrence D. Marcus, MD</i> | | 22c. DATE SIGNED
<i>2/4/69</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Lawrence Marcus, M. D.</i> | |
| 22e. ADDRESS
<i>1111 Spring St., Silver Spring,</i> | | 23a. BURIAL, CREMATION, REMOVAL (State)
<i>BURIAL</i> | | | |
| 23b. DATE
<i>2-7-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>MT ZION CEM.</i> | | 23d. LOCATION (City or Town), (County) (State)
<i>MT. ZION MONTG MD</i> | |
| 24. FUNERAL DIRECTOR
<i>George P. Brownlee</i> | | 25a. REC'D BY REGISTRAR
DATE
<i>FEB 11 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Judge</i> | |

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02687

CERTIFICATE OF DEATH

| | | | | | | | | |
|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(Type or print) Joseph S. Puzzo | | | 2a. DATE OF DEATH
Month Feb. Day 5 Year 1969 | | | 2b. HOUR
9:30 p.m. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
10/13/13 | | 6. AGE (In years last birthday)
55 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
DRIVER EDUC. INSTRUCTOR | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY MONTGOMERY | | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
12805 Parkland Drive | |
| 14. FATHER'S NAME First Anthony J. Middle Puzzo Last Puzzo | | | | 15. MOTHER'S MAIDEN NAME First Vincent Middle Cannizzo Last Cannizzo | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> YES 1941-1945 | | | | 16b. SOCIAL SECURITY NO.
577-18-8574 | | 17. INFORMANT
WINIFRED M. PUZZO Address 13a, b, c, d, e above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral pulmonary atelectasis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumothorax
DUE TO, OR AS A CONSEQUENCE OF
(c) Advanced Bulloous Emphysema
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary Infarction | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks | |
| 19a. DATE OF OPERATION
1/21/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pneumothorax | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21 , 19 69 , to 2/5 , 19 69 , that (I) (we) last saw the deceased alive on 2/5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Marvin L. Kolkin | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2/6/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
MARVIN L. KOLKIN | | | | 22e. ADDRESS
1015 Spring St., S. S. Md. | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)
BURIAL | | 23b. DATE
10 FEB 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION (City or Town) (County) (State)
SILVER SPRING MD. | | |
| 24. FUNERAL DIRECTOR
PINADI FUNERAL HOME, INC. WASHINGTON, DC 20012 | | | | 25a. REC'D BY REGISTRAR
FEB 14 1969 | | 25b. REGISTRAR'S SIGNATURE
(Signature) | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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